

Victims of Our Success: Education and Ethics in a Time of HIV/AIDS, Lessons from Nairobi for the Future

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Victims of Our Success

Education and Ethics in a Time of HIV/AIDS:
Lessons from Nairobi for the Future

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ACRONYMS

What follows is a list of acronyms commonly used throughout this paper. Each will be spelled out on first reference but all are listed here for convenience.

ABC	Abstain, be faithful, use condoms—the most common approach to HIV prevention in sub-Saharan Africa.
AHAPPY	AJAN HIV/AIDS Prevention Programme for Youth—a curriculum developed by AJAN to prevent the spread of HIV and AIDS and to educate young people holistically.
AIDS	Acquired Immune Deficiency Syndrome—the final stage of HIV which causes severe damage to the immune system.
AJAN	African Jesuit AIDS Network—a network of Jesuit priests in sub-Saharan Africa involved in the ministry of AIDS care and HIV prevention.
ART	Antiretroviral therapy—a type of drug regimen used to manage HIV that can prevent or delay the onset of AIDS.
CBO	Community-based organization—an organization that focuses on working with a specific, small, independent community on a particular issue.
CDC	Centers for Disease Control and Prevention—the national public health institute of the United States.
GDP	Gross domestic product—a key indicator of a country’s economic condition.
GLBTQ	Gay, lesbian, bisexual, transgender, queer/questioning—an inclusive acronym used to describe the group of people who identify as one of the above (less frequently, LGBTQ, or LGBTI, for intersex).
GUD	Genital ulcer disease—any sexually transmitted disease that causes genital ulcers, such as syphilis or herpes.
HDI	Human Development Index—a composite development statistic that combines life expectancy, education, and income data.
HIV	Human Immunodeficiency Virus—a general term for the several different lentiviruses that can cause AIDS.

HIV+	HIV positive—indicates a person who is living with HIV, but not necessarily AIDS.
IDU	Intravenous drug users—often have higher risk of HIV infection.
KNACC	Kenyan National AIDS Control Council—a council established by President Moi in 1999 to control the spread of HIV/AIDS.
NASCOP	National AIDS and STI Control Programme of Kenya—an organization established in 1987 to spearhead the Ministry of Health’s response to HIV/AIDS.
NGO	Non-governmental organization—a large and diverse definition that includes organizations that work towards social goals without direct connection to a government or political party.
NIAID	National Institute of Allergy and Infectious Diseases—one of the institutes that makes up the National Institutes of Health.
NIH	National Institutes of Health—a biomedical research facility under the auspices of the U.S. Department of Health and Human Services.
ODA	Official development assistance—a term used to refer to the total amount of international aid flowing from one country to another.
PCP	<i>Pneumocystis carinii</i> pneumonia—a relatively rare disease in the West that was common in early AIDS patients.
PEPFAR	President’s Emergency Plan for AIDS Relief—a commitment of USD \$15 billion made by President George W. Bush to fight the global HIV/AIDS pandemic.
PMTCT	Prevention of mother to child transmission—usually accomplished through antiretroviral medication and specific birthing procedures.
PSI	Population Services International—a non-governmental organization that works to promote health and education in the developing world.
SIV	Simian immunodeficiency virus—a retrovirus that infects primates the same way HIV infects humans, thought to be a precursor to HIV.
SJ	Society of Jesus—indicates a person’s membership in the Society of Jesus (Jesuits), a male religious congregation of the Roman Catholic Church founded in 1534 by St. Ignatius of Loyola.

STI	Sexually transmitted infections—a broad phrase that includes all infections transmitted sexually, of which HIV/AIDS is one.
TRIPS	The Agreement on Trade Related Aspects of Intellectual Property Rights—an international agreement made in 1994 that sets standards for international intellectual property law.
UKAID	United Kingdom Department for International Development—an agency of the U.K. government that administers foreign aid.
UNAIDS	Joint United Nations Programme on HIV/AIDS—an advocacy organization which focuses on cooperative global efforts to stop the spread of HIV/AIDS.
USAID	United States Agency for International Development—a U.S. government agency that administers foreign aid.
VTC	Voluntary testing and counseling—the process of determining one’s HIV status through medical testing and then working with health professionals to address the result.
WHO	World Health Organization—an agency of the United Nations that is concerned with international public health.

This project is dedicated to the students of
St. Aloysius Gonzaga Secondary School in
Nairobi, Kenya.

PREFACE:

What Will This Paper Do?

As deaths due to HIV/AIDS continue to mount around the world after more than 30 years, one question has been raised more than all others: when will this end? While research on HIV cures and statistics on infection and transmission have been promising of late, with total new infections worldwide decreasing since 2001, the answer to this question is quite simple: we don't know.¹ We don't know when HIV/AIDS will be cured, and we don't know when the last death that results from the virus and its associated complications will be. What we do know is that HIV/AIDS continues to cause the deaths of millions of people—1.7 million in 2011 alone—particularly in

¹ UNAIDS, “UNAIDS Report on the Global AIDS Epidemic,” (Geneva, 2012), 9; for accounts of recent work into cures for HIV, see Erik Ortiz, “Early signs for HIV cure are ‘promising’ as Danish scientists begin test on humans,” *The New York Daily News*, April 28, 2013.

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areas of immense poverty and instability, like Sub-Saharan Africa.² This information shows that despite the encouraging statistics on new infections and the promise of some research into cures, more needs to be done to prevent the spread of HIV/AIDS in the immediate future.

This paper's title indicates that it focuses on Nairobi, Kenya. Some of the content is derived directly from experience living and working in Nairobi, specifically in Kibera, Africa's largest urban slum. Relevant anecdotes from this experience will be included in the footnotes, and occasionally interspersed throughout the discussion. Drawing on the expertise and opinions of a large variety of experts who interact regularly with the problem of HIV/AIDS in Kenya—either as educators, doctors, or relief workers—this paper will synthesize diverse perspectives into specific lessons that can be drawn from the state of the HIV/AIDS epidemic in Nairobi. While the lessons presented here are specific to that city (or at least that country), they can also be extrapolated into a larger context as more general lessons that can assist the fight against HIV/AIDS across the globe.

In order to give context to the problem of HIV/AIDS in Kenya, this paper will open with an overview of the global problem of HIV/AIDS, beginning with its earliest history, the discovery of AIDS and, later, HIV, and the methods of prevention that have yielded results up to the present day. Despite the paper's specific focus, it must not be forgotten at any point that HIV/AIDS has effects around the world in nearly every single country, rich or poor, large or small, European or African. Next, we will turn to Kenya to analyze the history of the fight against HIV/AIDS there through various education and prevention strategies. Proceeding chronologically, current practices for fighting HIV/AIDS in Nairobi—religious, educational, and governmental alike—will be discussed.

² UNAIDS, "UNAIDS Report on the Global AIDS Epidemic," 12, http://www.unaids.org/en/media/unaids/content/assets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

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Upon analyzing these past and current responses to the HIV/AIDS crisis, the various ethical issues that have arisen in relation to HIV/AIDS will be addressed. HIV/AIDS is not just a biological problem—it is an ethical problem, as well. Disproportionate effects on women, stigma against HIV+ people, and the crippling effects of poverty are just a few of the ethical issues that come into play when discussing HIV/AIDS and the various ways of combatting it. All of these issues both exacerbate and are exacerbated by the HIV/AIDS epidemic. A significant portion of this paper will be dedicated to discussing them in detail, with particular attention to how the global community can work to mitigate their effects.

The final part of this paper will focus on taking the information gathered in the aforementioned sections and drawing from it a variety of suggestions for moving forward in the context of the realities facing sub-Saharan Africa today. In many ways, Kenya has become a victim of its success. The government, in coordination with many Western nations and non-governmental organizations, has so successfully mainstreamed HIV/AIDS and the problems associated with it that the population has reached a point of inundation. As a result, donations for HIV/AIDS education and prevention have begun to fall off, resulting in the cessation of many HIV/AIDS programs—in 2010, total HIV assistance worldwide declined by 10 percent, according to the Joint United Nations Programme on HIV and AIDS (UNAIDS).³

This unique and precarious situation is not unprecedented in the relatively short history of HIV/AIDS. Particularly developed countries like the United States have fallen victim to so-called “AIDS Fatigue,” and some nations in sub-Saharan Africa have, as well.⁴ While progress is promising, it is in no way a sign of the end of HIV/AIDS. In a 2011 report, Kenya’s own AIDS Control Council wrote: “In other countries in sub-Saharan Africa and elsewhere, progress against

³ Ibid.

⁴ Anthony Fauci, “Fauci: Despite AIDS Fatigue, Americans Should Care,” *CNN*, November 30, 2007.

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HIV has sometimes been followed by a resurgence of the epidemic, underscoring the critical importance of continuing vigilance.”⁵ If Kenya has reached this perilous state of near-complacency towards HIV/AIDS despite having such a large percentage of the population living with the virus, it can be predicted that other African nations will, in their own way and in their own time, reach a similar state. The lessons we learn from Kenya can thus help inform HIV/AIDS prevention on a broader level.

The problems associated with HIV/AIDS and the factors influencing its spread and prevalence are complex. Effective responses to HIV/AIDS are equally complex. Using Nairobi as a microcosm of the greater environment of sub-Saharan Africa, we can gather important lessons that will inform future prevention strategies. Western norms and attitudes towards HIV/AIDS simply have not and will not work in a Kenyan context, because they grow from a completely different situation and set of experiences. Rather, what must be developed is a socially and culturally specific strategy that responds directly to HIV/AIDS and the various ethical issues with which it is associated—gender inequality, poverty, political instability, and pharmaceutical access, among others—directly where each of these issues are located. This is the challenge that this paper takes head on.

⁵ National AIDS Control Council (NACC) and National AIDS and STI Control Programme (NAS COP), “Kenya AIDS Epidemic Update 2011,” 2012.

Part One:

HIV/AIDS and Kenya

CHAPTER ONE

Introduction to the Global HIV/AIDS Pandemic

Without global context, any discussion of HIV/AIDS in a specific scenario risks being misleading. The following section highlights important developments in the history of AIDS, including the discovery of the disease and its causative agent, HIV; early responses to the disease; and the global spread of the epidemic. In order to evaluate the success or failure of the various methods of HIV/AIDS prevention and education in Kenya that will be discussed later, one must first begin with an overview of the problems the world has faced—and continues to face—at the frontlines of the fight against HIV/AIDS.

Beginnings and Discovery

Acquired immunodeficiency syndrome (AIDS) was identified as a disease in 1981 in the United States, after a series of troubling and curious medical cases, primarily among homosexual men. In July of that year, *The New York Times* published an article titled “Rare Cancer Seen in 41 Homosexuals,” which detailed the cases of gay men in New York and California afflicted by Kaposi’s sarcoma, a previously very rare form of cancer in young Westerners.⁶ At the time, AIDS had not yet been identified by name, but cases of Kaposi’s sarcoma and other rare diseases like *pneumocystis carinii* pneumonia (PCP) were appearing in large numbers among young, gay, American men who otherwise were quite healthy.⁷ By the end of 1981, more than 270 cases of severe immune deficiency were reported in homosexual men, and 121 of those men had already died.⁸

Because so many of the emerging AIDS cases during the early 1980s were among homosexual men, the term “Gay-Related Immune Deficiency” came into use among both healthcare providers and the media.⁹ Beginning near the end of 1981, however, irregular cases of immune deficiency began to spread to more diverse populations.

Over the following two years, several other communities began to show high rates of AIDS cases, including hemophiliacs, Haitians, intravenous drug users (IDUs), blood transfusion recipients, and travelers from central Africa.¹⁰ One early name for AIDS, suggested by the CDC,

⁶ Lawrence K. Altman, “Rare Cancer Seen in 41 Homosexuals,” *The New York Times*, July 3, 1981.

⁷ Max Essex, et al., *AIDS in Africa* (New York: Kluwer Academic/Plenum Publishers, 2002), 1.

⁸ U.S. Department of Health and Human Services, *A Timeline of AIDS*, 2011, accessed January 22, 2014, <http://aids.gov/hiv-aids-basics/hiv-aids-101/aids-timeline/>.

⁹ Altman, “Rare Cancer.”

¹⁰ U.S. Department of Health and Human Services, *A Timeline of AIDS*, 2011, accessed January 22, 2014.

was the “4-H Disease,” as the disease appeared to affect Haitians, homosexuals, hemophiliacs, and heroin users disproportionately.¹¹

The term AIDS was first used by the Centers for Disease Control and Prevention (CDC) in 1982, in a document which offered the first working definition of that term:

CDC defines a case of AIDS as a disease, at least moderately predictive of a defect in cell-mediated immunity, occurring in a person with no known cause for diminished resistance to that disease ... However, this case definition may not include the full spectrum of AIDS manifestations, which may range from absence of symptoms ... to non-specific symptoms (e.g., fever, weight loss, generalized, persistent lymphadenopathy) to specific diseases that are insufficiently predictive of cellular immunodeficiency to be included in incidence monitoring (e.g., tuberculosis, oral candidiasis, herpes zoster) to malignant neoplasms that cause, as well as result from, immunodeficiency.¹²

AIDS quickly became the widely accepted name for the disease, as it was descriptive of the disease’s effects and both less pejorative and more inclusive than GRID or 4-H. Yet despite the new name, the cause of the disease remained unknown in the early 1980s.

As AIDS spread across communities, leaving behind the niche environments in which it was first identified, experts began considering it as an infectious disease. Research carried out during the 1970s, in the years immediately prior to the outbreak of AIDS, had identified the first human retroviruses, yet many public health officials of the time remained unaware of their existence.¹³ Even those who suggested a viral agent as the cause of AIDS were hesitant, because most viral infections at the time were known to have short incubation times, whereas AIDS had an incubation time of four to five years. Furthering this confusion was that the actual cause of death from AIDS varied greatly across the globe and even within the United States. In some cases, people

¹¹ Edward P. Richards and Katharine C. Rathbun, *Law and the Physician: A Practical Guide* (New York: Little Brown and Company, 1993).

¹² Centers for Disease Control and Prevention, “Current Trends Update on Acquired Immune Deficiency Syndrome (AIDS) -- United States,” *Morbidity and Mortality Weekly Report*, September 24, 1982, 507-8.

¹³ B.K. Poiesz, G.W. Ruscetti and A.F. Gazdar, “Detection and Isolation of Type C Retrovirus Particles from Fresh and Cultured Lymphocytes of a Patient with Cutaneous T-cell Lymphoma,” *Proceedings of the National Academy of Sciences* 77 (1983): 7415-9.

with AIDS died of tuberculosis, in others, of various pneumonias, in still others, of what doctors at the time called “slim disease,” an intense onset of weight loss and diarrhea.¹⁴

In February of 1983, Dr. Robert Gallo of the National Institutes of Health (NIH) suggested publicly that a retrovirus might be the cause of AIDS.¹⁵ In May of the same year, the U.S. Congress passed the first bill that specified AIDS as the target of federal funding—pledging USD \$12 million in AIDS research funding for the Department of Health and Human Services.¹⁶ In September, the CDC issued the first official document which identified the major routes of transmission of AIDS: sexually and through infected blood.¹⁷ The same document ruled out transmission by casual contact, food, water, or air, but many remained skeptical of these claims in the years to follow.¹⁸

Though Gallo had expressed his belief that AIDS was caused by a retrovirus, his research team had not yet proved it. During the early 1980s, both Gallo and Luc Montagnier, a French virologist and researcher at the Pasteur Institute, dedicated themselves to researching the cause of AIDS. In 1983, the two groups independently published the results of their work in *Science*. They had both isolated a retrovirus from patients presenting with immune deficiency, they both showed that that retrovirus caused AIDS, and they each had given it a different name. In 1986, the two viruses were found with near certainty to be the same—confirming both Montagnier and Gallo’s

¹⁴ Essex, et. al., 2. The “slim disease” was at first thought to be distinct from both HIV/AIDS and dysentery. What was often considered “slim disease” during the time was later shown to be either dysentery or a symptom of HIV/AIDS.

¹⁵ U.S. Department of Health and Human Services, *A Timeline of AIDS*, 2011, accessed January 22, 2014.

¹⁶ Ibid.

¹⁷ Centers for Disease Control and Prevention, “Current Trends Update: Acquired Immunodeficiency Syndrome (AIDS) -- United States,” *Morbidity and Mortality Weekly Report*, September 9, 1983, 465-7.

¹⁸ Ibid.

previous suspicions—and were renamed to human immunodeficiency virus, HIV, the name that remains in use today.¹⁹

Origin of HIV

HIV is thought to have originated in human beings during the mid-20th century, though there remains significant debate about the exact time and mechanism of infection. Following the determination of HIV as the causative agent of AIDS in the mid-1980s, many researchers turned their attention toward understanding the origin and development of the virus and its many strands, seeking to understand how it came to be both widespread and deadly to humans.

Today, most researchers at least agree that HIV evolved from simian immunodeficiency virus (SIV), a retrovirus that infects primates in essentially the same way that HIV infects humans.²⁰ SIVs are common in many primates, particularly in West Central African forests, and provide the most compelling hypothesis for the first HIV infections in human beings. The so-called “Hunter Theory” of HIV transmission—the most widely accepted theory today—argues that humans hunting primates in the mid-20th century were exposed to HIV, either by being bit or cut and then coming into contact with the blood of an infected primate while killing, eating, or preparing the animal.²¹ Although in most cases the human immune system would destroy SIV, in rare cases, researchers argue, the virus adapted in its human host to become HIV, which subsequently could be passed to other humans by the routes we know of today.²² The theory is

¹⁹ Robert C. Gallo, et al., “Isolation of Human T-Cell Leukemia Virus in Acquired Immune Deficiency Syndrome (AIDS),” *Science* 220, no. 4599 (1983): 865-7; Luc Montagnier, et al., “Isolation of a T-Lymphotropic Retrovirus from a Patient at Risk for Acquired Immune Deficiency Syndrome (AIDS),” *Science* 220, no. 4599 (1983): 868-71.

²⁰ Donald G. McNeil, “Precursor to H.I.V. was in Monkeys for Milleniums,” *The New York Times*, September 16, 2010.

²¹ AVERT, “Origin of HIV & AIDS,” *HIV and AIDS Information and Resources*, accessed January 23, 2014; P.M. Sharp, et al., “The Origins of Acquired Immune Deficiency Syndrome Viruses: Where and When?” *Philosophical Transactions of the Royal Society B: Biological Sciences* 356 no. 1410 (2001): 867-76.

²² AVERT, “Origin of HIV & AIDS.”

supported by direct evidence, including a 2004 publication in *The Lancet*—one of the world’s oldest and best known medical journals—which showed that SIV was still being transferred from primates to humans in Cameroon, 30 years after HIV/AIDS emerged as a global epidemic.²³

While the “Hunter Theory” adequately explains the first few cases of HIV in humans—namely, that the virus was transferred from the blood of primates to the bodies of the human beings hunting them—it fails to explain how HIV became an epidemic, affecting millions of people across the globe. There are probably hundreds of conditions that allowed HIV to develop from a few isolated cases in primate hunters in West Central Africa to a modern epidemic that affects millions of people around the globe. Many of these causes probably remain unknown. It is important to note that work in this area is still developing, and HIV/AIDS researchers are often the first to point out that there is almost no way to know exactly how the virus became so widespread. Discussed below are a few of the most widely supported examples, which illustrate in a common sense fashion how Africa’s history during the 20th century allowed for HIV to become the dominant modern epidemic.

The Heart of Darkness Theory

Chronologically, the first widely-accepted contributor to the AIDS epidemic began as far back as the 1880s, when the “Scramble for Africa” resulted in the colonization of nearly the entire continent by white Europeans. Soon after arriving, the colonial rulers of African provinces subjected the local population to harsh treatment and forced labor, which many researchers argue increased the prevalence of bushmeat hunting, both due to a need for more food for the workforce

²³ N.D. Wolfe, et al., “Naturally Acquired Simian Retrovirus Infections in Central African Hunters,” *The Lancet* 363 no. 9413 (2004): 932-7.

and a larger supply of firearms.²⁴ In turn, the increase in bushmeat hunting led to more cases of SIV transmission to humans, while harsh conditions and displacement suppressed the immune systems of oppressed workers and increased the rates of prostitution in labor camps.²⁵ This theory that colonial oppression contributed to the spread of HIV, known as the “Heart of Darkness” theory after Joseph Conrad’s novel of the same name, has received broad support. In his book, *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa*, Philip Setel, who now works for the Bill and Melinda Gates Foundation, writes, “the links between the movement of labor and disease in general have been well documented, and STDs were no exception.”²⁶ As Africans were plucked from their homeland, trafficked around the continent, and forced to build cities and railroads under abominable conditions, HIV slowly spread from isolated cases to densely populated urban centers.

A highly related sociological theory posits that the large scale urbanization that occurred in Africa—mostly as a result of colonization—led to a perfect storm of circumstances which facilitated the rapid spread of HIV. Paul Sharp et al. write that the rapid spread of HIV/AIDS as an epidemic in the second half of the 20th century was likely the result of “changes in population structure and behavior in Africa,” most of which were driven by urbanization and unprecedented movements of African populations.²⁷ Their research was not performed in a vacuum, but was instead one possible answer to a very pressing and obvious question: if HIV was present in humans as far back as the early 20th century—as their research showed was the case—why did it take so

²⁴ A. Chitnis, et al., “Origin of HIV Type 1 in Colonial French Equatorial Africa,” *AIDS Research and Human Retroviruses* 16 no. 1 (2000): 5-8.

²⁵ Chitnis, et al.

²⁶ Philip Setel, et al., *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa* (Westport: Greenwood Press, 1999), 4.

²⁷ Sharp, et al.

many decades for the virus to become an epidemic?²⁸ Other researchers took Sharp's assertion about changes in population structure and set about proving it.

Sexuality and Promiscuity

Before colonization, African society beneath the Sahara was almost exclusively tribal, with the continent's culture largely established by traditional tribal customs and rituals. As such, these tribal customs are highly relevant to a discussion of the early spread of HIV. For example, research by Joao Dinis de Sousa et al. shows that under tribal customs, almost the entirety of pre-colonial Africa had rates of promiscuity far lower than Western nations of the time.²⁹ This was mostly a result of tribal African customs, which valued abundant life—and thus, reproduction—but stressed unequivocally the importance of fidelity and monogamy, limiting promiscuity among young tribal Africans.³⁰ In his book *African Religion: The Moral Tradition of Abundant Life*, Tanzanian theologian Laurenti Magesa discusses traditional African marriage, and it quickly becomes evident how such a society would have low rates of promiscuity. Many African tribes practiced transactional marriage, in which a bride was given to a man along with “bride-wealth”—a combination of goods and livestock that would then be used to nurture a family and produce children.³¹ In some cases, Magesa shows, the onus was upon the couple to produce children, and the bride-wealth would only be paid out upon successful procreation.³² Though tribal African societies had (and continue to have) many problems with the way in which they treat women, these

²⁸ Sharp, et al.

²⁹ J.D. de Sousa, et al., “High GUD Incidence in the Early 20th Century Created a Particularly Permissive Time Window for the Origin and Initial Spread of Epidemic HIV Strains,” *Public Library of Science*. April 1, 2010.

³⁰ Laurenti Magesa, *African Religion: The Moral Tradition of Abundant Life* (New York: Orbis Books, 1997) 115-9.

³¹ *Ibid.*, 128-30.

³² *Ibid.*, 130.

transactional marriages were strict and highly honored, rooted strongly in procreation and sexual relations between a single man and a single woman.

Upon colonization, however, Africans were met with the technological advances of railways, the alluring and modern nature of cities and sea ports, and freedoms that had not been available under tribal rule. Slowly but surely, tribal customs broke down and Africans were set free—for better or for worse—from the cultures that had established what Magesa aptly calls “the moral tradition of abundant life”: the combination of traditional beliefs that valued sexuality but controlled promiscuity and, in turn, the spread of sexually transmitted infections.³³

De Sousa et al. argue in their paper that, in particular, “gender-skewed city growth” resulted in “increasing sexual promiscuity” among Africans.³⁴ Cities were built largely on the backs of native male Africans, and as such they were brought from the continent’s interior to growing port cities in large groups to provide forced labor. As native Africans were transported and trafficked across the continent from colonial city to colonial city, they left behind tribal borders and the rules that had once guided their behavior. The result was growing promiscuity in these modern cities, with more women remaining unmarried for long periods and more divorces. Having a higher proportion of men to women in growing colonial cities, de Sousa argues, only added to the promiscuity of the time.³⁵

The researchers also argue that high rates of genital ulcer diseases (GUD) present in Africa during the second half of the 20th century contributed to increased HIV transmissibility and, in turn, a higher rate of HIV/AIDS among colonial populations.³⁶ In their paper, they point out that

³³ Ibid., 1.

³⁴ De Sousa, et al., 116.

³⁵ De Sousa, et al., 116.

³⁶ GUD refers not to a specific sexually transmitted disease, but to any STD that results in genital ulcers. Common examples include syphilis and genital herpes.

HIV transmissibility in a sexually active couple with GUD could be from four to as high as 43 percent.³⁷ Estimates for HIV transmissibility in couples without GUD, on the other hand, are generally less than one percent per sex act according to modern healthcare agencies.³⁸ According to their research, this massive increase in transmissibility occurred only in the second half of the 20th century, thus de Sousa et al. argue that it contributed greatly to the spread of HIV among vulnerable populations.

There are additional arguments for the rapid spread of HIV/AIDS in the realm of sexuality and promiscuity. Many experts have pointed to changes in sexual behavior in the 20th century as perhaps contributing to the spread of HIV/AIDS. Take an example: a woman who participates in receptive anal intercourse is, on average, nearly ten times more likely to contract HIV/AIDS than in typical receptive vaginal intercourse.³⁹ Thus, if for some reason anal intercourse were to become more common, it is reasonable to believe that HIV/AIDS infection rates would similarly increase. In the U.S. and other developed nations, many experts point to the sexual revolution of the 1960s and 1970s as perhaps contributing to greater acceptance of non-traditional sexual behaviors, including anal intercourse. In fact, sodomy laws in the United States, which were historically universal, began getting repealed in the 1960s, with the majority of states repealing them in the 1970s and 1980s and the Supreme Court universally striking down all sodomy laws in 2003.⁴⁰ As these sodomy laws were repealed and modern society became increasingly accepting of same-sex

³⁷ De Sousa, et al., 117.

³⁸ Transmissibility of HIV is highly circumstantial, and estimates range wildly as a result of A) data that is difficult to obtain objectively and B) large variation based on the nature of the sex act. The widely supported rate for transmission of HIV for vaginal intercourse between a male and female is around 0.1 percent and slightly higher rates (around 1 to 2 percent) for receptive anal intercourse. There is significant deviation depending on which partner is HIV+, with women generally having more vulnerability to infection than men, for data see: Public Health Agency of Canada, "HIV Transmission Risk: A Summary of Evidence," February 19, 2013.

³⁹ Ibid.

⁴⁰ Margot Canaday, "We Colonials: Sodomy Laws in America," *The Nation*, September 3, 2008.

relationships, it is possible that rates of anal intercourse increased, which in turn could lead to a greater transmissibility of HIV/AIDS on average.

Injections

Another widely cited cause of the HIV/AIDS epidemic is one that continues to be a problem among intravenous drug users (IDUs) around the world: unsterile injections. In a 2001 paper, Preston Marx et al. pointed to “the rapid growth of unsterile injections in Africa beginning in the 1950s as a biologically plausible event capable of greatly increasing serial human passage of SIV and generating HIV by a series of multiple genetic transitions.”⁴¹ Antibiotics, which were researched and developed significantly in the early to mid-20th century, had come into wide use among developed countries around the time of African colonization. Their powerful effects were widely known, and they were quickly put to use in Africa, massively increasing the number of injections on the continent.

Marx gives several reasons for this. First, he points out that global syringe production skyrocketed in the middle of the 20th century, increasing from 100,000 per year in 1920 to more than 8 million per year by 1952.⁴² This was a result of increasing mechanization and less concern over the precision of the syringes, which allowed for more rapid and inexpensive manufacture. Penicillin, which came into wide use in the 1950s, provided a demand for syringes greater than any before. This led to the creation of plastic “single-use” syringes, which were inexpensive and were intended to be disposed of after one use because the plastic could not withstand the

⁴¹ Preston A. Marx, et al., “Serial Human Passage of Simian Immunodeficiency Virus by Unsterile Injections and the Emergence of Epidemic Human Immunodeficiency Virus in Africa,” *Philosophical Transactions of the Royal Society B: Biological Sciences* 356 no. 1410 (2001): 911-20.

⁴² Marx, et al.

sterilization process. Despite their intended use, however, disposable syringes flooded into Africa and were reused over and over again, “often without even attempts at sterilization.”⁴³

While pre-World War II injection campaigns in Africa were relatively well organized, with generally sterile equipment and safe practices, post-WWII campaigns were not. As European colonial powers began to lose their grip on their African colonies, their control of medical practices and civic policies also began to slip. As Europeans retreated from their colonies, sterilization standards fell. Many indigenous practitioners began running injection clinics, with “little or no awareness of the need or the capability for sterilization procedures.”⁴⁴

Despite the departure of European powers, injection campaigns did not cease. Throughout the years after 1950, Birungi et al. show a drastic increase in injections in sub-Saharan Africa—according to Marx, they became “expected at any medical visit and for the treatment of any condition.”^{45, 46, 47} Astonishingly, several independent studies show that, by the 1960s, more than 75 percent of households in sub-Saharan Africa had received an injection within two weeks of survey.⁴⁸

There is a preponderance of evidence that injections generally contributed to the spread of HIV and the development of the epidemic.⁴⁹ The high rates of antibiotic injections after penicillin was introduced in the 1950s were preceded by many injections against African sleeping sickness, trypanosomiasis, between 1910 and 1940.⁵⁰ Other researchers show high rates of unsterile

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ H. Birungi, D. Asimwe and S.R. Whyte, *Injection Use and Practices in Uganda: World Health Organization Action Program on Essential Drugs*, (World Health Organization, Geneva, Switzerland: 1994).

⁴⁷ Alexander Alland, *Adaptation in Cultural Evolution: An Approach to Medical Anthropology* (New York: Columbia University, 1970).

⁴⁸ Birungi, et al.

⁴⁹ Essex, *Aids in Africa*, 225.

⁵⁰ David Gisselquist, “Emergence of the HIV Type 1 Epidemic in the Twentieth Century: Comparing Hypotheses to Evidence,” *AIDS Research and Human Retroviruses* 19 no. 12 (2003): 1071-8.

intravenous injections for diseases like leprosy, yaws, and syphilis, as well—yielding an even higher risk of transmission of HIV than subcutaneous injection.⁵¹

Given this evidence, it is difficult to find a way in which injections might not have contributed to the spread of HIV/AIDS in Africa. Massive injection campaigns against diseases like sleeping sickness, hepatitis, and syphilis, combined with reused, low-quality syringes undoubtedly resulted in the infection of thousands of sub-Saharan Africans with HIV in the early stages of the disease's spread. In time, this silent transmission of a killer virus would explode into the global spotlight, bringing about the deaths of millions of people in the years since.

Circumcision

Many experts cite lack of circumcision among African men during the 20th century to be an additional contributor to the HIV/AIDS pandemic. Circumcised men, in general, have a lower risk of HIV/AIDS infection than uncircumcised men.⁵² There are several legitimate and widely-accepted biological reasons for this.

Many studies have shown, for example, that “compared with the dry external skin surface of the glans penis and penile shaft, the inner mucosa of the foreskin has ... a higher density of target cells for HIV infection.”^{53, 54} Circumcision not only reduces the surface area of the penis that is exposed to potential invasion by HIV, however. According to many researchers, it also removes significantly more vulnerable tissues. Many studies have shown that the foreskin itself is

⁵¹ Jacques Pepin and Annie-Claude Labbe, “Noble Goals, Unforeseen Consequences: Control of Tropical Diseases in Colonial Central Africa and the Iatrogenic Transmission of Blood-Borne Viruses,” *Tropical Medicine and International Health* 13 no. 6 (2008): 744-53; Jacques Pepin, *The Origin of AIDS* (New York: Cambridge University Press, 2011).

⁵² Essex, 222, 503-4.

⁵³ T. Hirbod, et al., “Abundant Expression of HIV Target Cells and C-type Lectin Receptors in the Foreskin Tissue of Young Kenyan Men,” *The American Journal of Pathology* 176 no. 6 (2010): 2798-805.

⁵⁴ Centers for Disease Control and Prevention, “Male Circumcision,” *Division of HIV/AIDS Prevention*, April 15, 2013, accessed January 31, 2014.

more likely to be invaded by HIV than the other penile tissues, but debate remains over the reliability of this data.⁵⁵ One risk factor that is widely-accepted, however, is that the foreskin has a higher probability of tears and damage during sexual intercourse.⁵⁶ It is clear that damage to epithelial tissues would greatly increase vulnerability to HIV. A final additional consideration is the potential for the unretracted foreskin to provide an environment that could incubate and prolong the life cycle of the virus.⁵⁷

Physicians and public health workers long suspected the benefits of circumcision in limiting the transmission of HIV/AIDS, and many researchers in the second half of the 20th century turned their attention toward proving it empirically while analyzing the history of circumcision among traditional African tribes.

In their paper on GUD incidence in the early years of HIV, de Sousa et al. also analyzed the effects of male circumcision, beginning their section on the issue quite matter of factly: “Male circumcision reduces the risk of HIV acquisition in men, and HIV/AIDS prevalence correlates inversely with the level of male circumcision in Africa.”⁵⁸ Armed with a hypothesis—that not only were rates of circumcision in central Africa lower during the early years of HIV than they are today, but also that areas of low circumcision correlated geographically with future epicenters of the HIV epidemic—de Sousa et al. went about investigating the issue.

Using ethnographic papers, de Sousa et al. were able to confirm their hypothesis that, in general, circumcision rates are higher today in Central and West Africa than they were in the early to mid-20th century (Figure 1). As colonization took hold of the continent, many ethnic groups that

⁵⁵ Ibid.

⁵⁶ R. Szabo and R.V. Short, “How Does Male Circumcision Protect Against HIV Infection?” *British Medical Journal* 320 no. 7249 (2000): 1592-4.

⁵⁷ B.K. Patterson, et al., “Susceptibility to Human Immunodeficiency Virus-1 Infection of Human Foreskin and Cervical Tissue Grown in Explant Culture,” *American Journal of Pathology* 161 no. 3 (2002): 867-73.

⁵⁸ De Sousa, et al.

had not traditionally practiced circumcision began to adopt the practice so that their young men could assimilate into the increasingly ethnically intermixed African population.⁵⁹

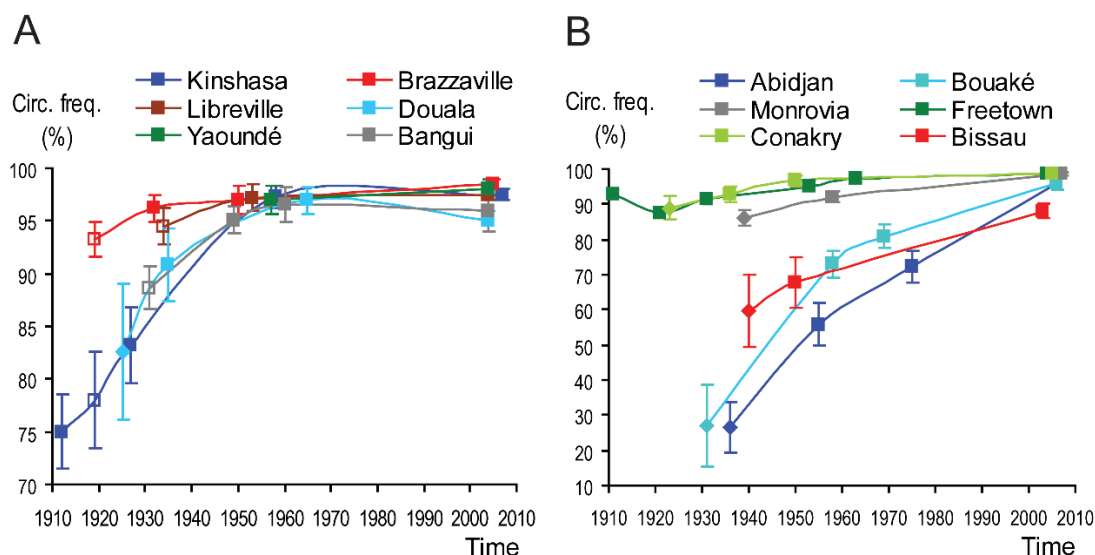


Figure 1. Estimated male circumcision rates in Central (A) and Western African (B) cities.⁶⁰

In addition to proving that rates of circumcision have increased in Africa during the 20th century (and thus were lower in the early part of the century), de Sousa et al. also provided convincing data that linked some urban epicenters of early HIV strands, like Abidjan and Douala, to the lowest levels of circumcision. In order to investigate this issue, de Sousa et al. created “circumcision classes” that were “directly derived from the ethnographic literature and do not depend on additional assumptions.”⁶¹ These classes distinguished between circumcision practices—those African societies that did not practice circumcision at all and those that practiced circumcision around the time of puberty, for example—as well as at what point the practice began to change (45 years before, 30 to 45 years before, etc.). These results are summarized succinctly in Figure 2, which shows the changes in types of circumcision practice in African cities over time.

⁵⁹ Ibid.

⁶⁰ Ibid.

⁶¹ Ibid.

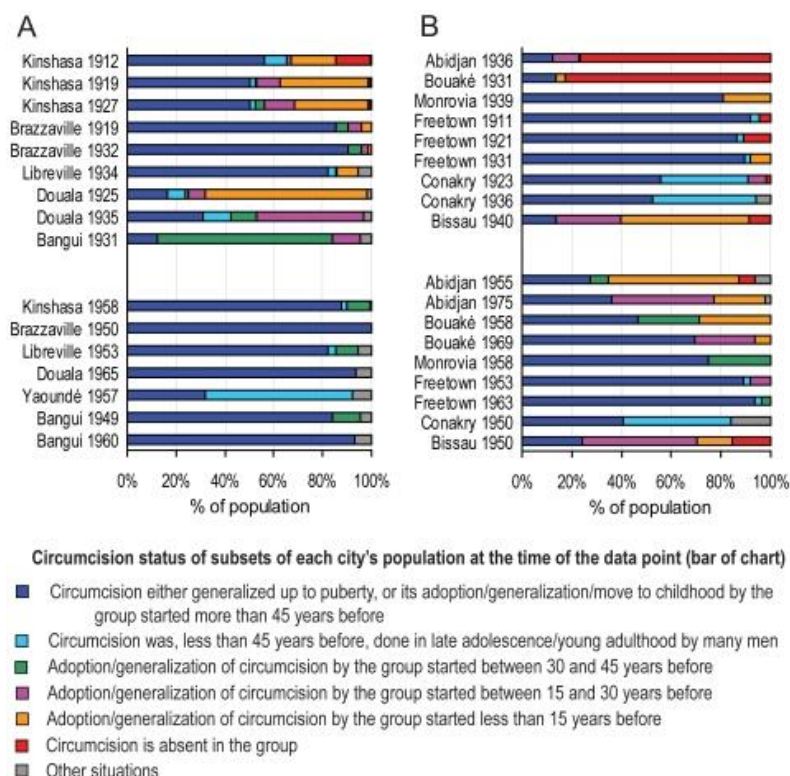


Figure 2. Male circumcision patterns in central (A) and west (B) African cities over time.⁶²

While male circumcision limits the risk of HIV transmission, female circumcision—a common African tribal practice—has been shown to increase HIV transmissibility significantly.⁶³ ⁶⁴ Much as anal intercourse increases the transmissibility of HIV due to ripping and tearing of the epithelial tissue and an increase of blood contact, Uli Linke argued early in the AIDS epidemic (1986) that female circumcision and genital mutilation can similarly increase contact between bodily fluids during intercourse:

In its most extreme form, referred to as “infibulation,” [female circumcision] consists of the removal of some or all of the vulval tissue, after which the two sides of the wound are sewn together, leaving only a small opening for the passage of urine and menstrual blood. Subsequent vaginal intercourse is therefore difficult if not impossible and is chronically associated with tissue damage, tears, and

⁶² Ibid.

⁶³ Uli Linke, “AIDS in Africa,” *Science* 231 no. 4375 (1986): 203.

⁶⁴ S. McLean and S.E. Graham, *Female Circumcision, Excision, and Infibulation* (London: Minority Rights Group, 1983).

bleeding. Anal intercourse is a common recourse for heterosexual partners. It is noteworthy that the recent outbreaks of AIDS in Africa, as reported at the Brussels meeting, correspond geographically to those regions in which female mutilation is still practiced.⁶⁵

Female circumcision in the African context to which this paper refers is often better described, then, as female genital mutilation—an operation or series of operations which severely alters, and, in many cases, permanently damages the genitals of female Africans. This inverse effect of circumcision practices on HIV transmissibility in men and women is particularly relevant in later discussion of gender inequity in HIV/AIDS prevalence and treatment.

Global Spread

Even upon showing all of these contributors to the epidemic, the picture is not entirely clear. Just as the early cases of AIDS were geographically isolated, the practices listed above—colonial oppression, unsafe injections, and female circumcision—were similarly isolated. How did HIV/AIDS make its global spread?

In 1969, a 15-year-old African American living in St. Louis, Robert Rayford, died of Kaposi's sarcoma. Almost 20 years later, researchers who tested his tissues found a virus that was nearly identical to HIV-1.⁶⁶ As *The New York Times* suggested following this new evidence, Rayford's death makes it clear that HIV invaded North America not just once, but several separate times.⁶⁷

One of the most widely accepted theories for HIV's spread to North America, however, centers around Haiti, which remains one of the poorest countries of the Western Hemisphere. As

⁶⁵ Linke, "AIDS in Africa"; Mclean, et. al.

⁶⁶ R.F. Garry, et al.

⁶⁷ Gina Kolata, "Boy's 1969 Death Suggest AIDS Invaded U.S. Several Times," *The New York Times*, October 28, 1987.

the 4-H name suggested, HIV/AIDS was observed in particularly high numbers among Haitians during the 1980s.⁶⁸ Many studies have linked this high rate of infection to contact between Haiti and Zaire (now, Democratic Republic of the Congo) in the 1960s following the withdrawal of Belgian troops.⁶⁹ Studies show with a high degree of reliability A) that many Haitians living in Africa during the 1960s were infected with HIV, B) that many of them returned to Haiti with the virus, and C) that the HIV virus group and subtype common in North America today was then transmitted to the United States from Haiti.⁷⁰ Later research by Worobey et al. shows that the “vast majority of non-Haitian subtype B infections in the United States and elsewhere around the world ... emerged after a single migration of the virus out of Haiti in or around 1969.”⁷¹

From Virus to Epidemic

We have now traced the movement of HIV from bushmeat hunters of Central and Western Africa to much of the native population in those areas as a result of several key contributing factors. According to the research cited above, the virus most likely entered the Western Hemisphere through Haiti (along with a few other, less contributing instances), and eventually to the United States and the rest of the world. Emerging most significantly in the 1980s—with a case in every major region of the world by 1985—HIV/AIDS has threatened the wellbeing of millions of human beings, particularly in the developing world.⁷²

So many factors have contributed to the spread of HIV that, with hindsight, it is almost obvious why the virus has become so widespread. HIV emerged in one of the world’s least

⁶⁸ Michael Carter, “CROI: Haiti is the Source of HIV Subtype B,” *AIDSmap*, March 2, 2007.

⁶⁹ Michael Worobey, “Exodus and Genesis: The Emergence of HIV-1 Group M Subtype B,” *Fourteenth Conference on Retroviruses and Opportunistic Infections*, oral abstract 149, Los Angeles, 2007.

⁷⁰ Ibid.

⁷¹ Michael Worobey, M.T. Gilbert, et al., “The Emergence of HIV/AIDS in the Americas and Beyond,” *Proceedings of the National Academy of Sciences of the United States of America* 104 no. 47 (2007): 18566-70.

⁷² U.S. Department of Health and Human Services, *A Timeline of AIDS*, 2011, accessed February 8, 2014.

developed, most unstable and impoverished regions, and, as a result, was provided with millions of routes of transfer. Each of these routes—unsterile injections, lack of male circumcision, harsh colonial oppression and mistreatment, increasing promiscuity and bushmeat hunting, high incidences of GUD, among dozens of others—combined with the virus’ long incubation period and unknown effects, allowed HIV to spread, slowly but surely, across all of sub-Saharan Africa and, eventually, the rest of the world. Worobey and his colleagues wrote that HIV circulated “cryptically” before its discovery, spreading throughout the world during the 1960s, ’70s and ’80s, in large part before AIDS had even been identified as a disease.⁷³ Then, like an exploding time bomb, the virus began taking its toll on the immune systems of those infected almost all at once. It took nearly ten years for the world to catch up to the source of these symptoms, and even longer to evaluate the various strategies of responding to it. Half a century since its earliest cases emerged, HIV/AIDS remains the dominant epidemic of the 21st century, taking the lives of more than 35 million people since its emergence in the 1980s.⁷⁴

⁷³ Worobey, et al.

⁷⁴ Nicholas Wade, “Europe’s Plagues Came from China, Study Finds,” *The New York Times*, October 31, 2010; UNAIDS, Geneva 2012.

CHAPTER TWO

History of HIV/AIDS in Kenya

We now turn our attention toward the heart of this paper: Kenya. We will begin with an introduction to the nation's history—both independent of and in relation to HIV/AIDS.

As a nation highly affected by HIV/AIDS, Kenya's history with the problem is relevant not only in and of itself, but also as a lens through which one can view the HIV/AIDS crisis in sub-Saharan Africa as a whole. Because of its relatively stable and developed economy in comparison to other sub-Saharan countries, Kenya has long been held up, particularly by Western nations, as a model of development and progress in a part of the world where development and progress are often hard to find. In the case of HIV/AIDS, this "role model" reputation is no different. In analyzing Kenya, then, insight can be gained about the ethical problems facing both Kenya and the rest of sub-

Saharan Africa. Lessons can then be drawn from these conclusions and can inform prevention strategies from a broader point of view.

Background

The Republic of Kenya is a nation of 44 million people (July 2013 est.) and is approximately twice the geographic size of the state of Nevada.⁷⁵ It is located in Eastern Africa, and borders the Indian Ocean, Somalia, Tanzania, Ethiopia, South Sudan, and Uganda. Its terrain is mixed between tropical coast, arid savannah throughout the country's interior, and some of the most fertile land in all of Africa in the highlands.⁷⁶ Its name is derived from Mount Kenya, the second highest mountain in all of Africa.

The people of Kenya are ethnically diverse, claiming allegiance to more than 50 traditional tribes and speaking more than 60 languages, though only English and Swahili are official languages. The vast majority of citizens (82 percent) identify as Christian, with the remainder being mostly Muslim—less than one percent is considered “traditionalist.”⁷⁷ A large number of problems face citizens of Kenya: 40 percent are without improved drinking water, 70 percent are without improved sanitation services, and the birth rate far exceeds the death rate, resulting in a bottom-heavy and rapidly growing population. Life expectancy at birth in Kenya is only 63.29 years, which ranks 180th in the world.⁷⁸ Education is relatively successful and is free and universal through primary school, resulting in a literacy rate of 82.1 percent among those 15 and older.⁷⁹

⁷⁵ Central Intelligence Agency, “Kenya,” *The World Factbook*, January 28, 2014, accessed February 1, 2014.

⁷⁶ Ibid.

⁷⁷ Ibid.

⁷⁸ Ibid.

⁷⁹ Ibid.

Most relevant for this discussion, however, is that 1.5 million people are living with HIV/AIDS in Kenya, fourth most in any country in the world and more than 6 percent of the nation's population (11th highest in the world).⁸⁰ Other infectious diseases are also widespread, including malaria, bacterial dysentery, hepatitis, typhoid, tuberculosis, rabies, and dengue fever.

History of Kenya

Kenya and the rest of the African Great Lakes region has been inhabited by human beings for more than one million years, making it one of the oldest sites of human existence on Earth.⁸¹ In 1984, archaeologist Richard Leakey and his team of researchers working in Kenya unearthed “Turkana Boy,” a 1.5 million year old, complete hominid skeleton of a boy whose age at death has been estimated to be roughly eight years.⁸² The Turkana Boy is the most complete early human skeleton ever unearthed, and remains in Kenya's national museum today. The Bantu language speakers that migrated across the African continent reached Kenya somewhere in the first millennium BC and established nomadic herder groups that would last for several centuries.⁸³ Swahili—one of Kenya's present-day official languages and the most widely spoken language in the country—is a Bantu language.

Not much is known about Kenya's history before the Common Era. Around the first century CE, however, Arab and Greek traders began frequenting Kenya's coast and established trading outposts which later became city-states. The establishment of Arab centers on Kenya's coast brought Islam to the tribal inhabitants, an influence that continues to last today.

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² F. Brown and R. Leakey, “Early Homo Erectus Skeleton from West Lake Turkana, Kenya.” *Science* 316 no. 6031 (1984): 788-92.

⁸³ Robin Halllet, *Africa to 1875: A Modern History* (Ann Arbor: University of Michigan, 1970), 31.

Traders rarely traveled beyond the coast, however. The interior of the continent was wild and unsafe, and it was far easier for those interested in purchasing goods—gold, ivory, and slaves, among others—to buy them off native Africans at the shore than venture in to hunt them down on their own.⁸⁴ Outside influence on Kenyan tribal society thus remained minimal during the early years of international interest.⁸⁵

After Vasco de Gama found a route around Africa to India, the Portuguese quickly gained interest in establishing control of trade around East Africa. Though they originally conquered the coasts of Kenya and Tanzania by force, they battled with the Omani Arabs perpetually for control of this trade route for spices from India. Eventually the Omani Arabs won out, established their capital in Zanzibar and consolidated power in the region for several hundred years.⁸⁶

Later, Europeans became interested in Africa as fertile ground for colonization and exploitation. Using Zanzibar—a regional cultural and trade hub—as a base, European explorers began boldly exploring the interior of the continent. Growing demand for African products in European countries drove exploration deeper, eventually leading the British government to intervene directly.

In 1895, the British government declared ownership of the East Africa Protectorate, a tract of land that covered much of current Kenya. That same year, colonial governors began the construction of a railroad from Mombasa, the premier port city and trading hub of Kenya, through Kisumu, a Kenyan city on Lake Victoria, to Kampala, the capital of Britain's profitable colony in Uganda (and today's Ugandan capital).⁸⁷ Although there was violent resistance to colonization and railroad construction by Kenyans at first, the superior manpower, resources, and technology of the

⁸⁴ Ibid, 227.

⁸⁵ BBC News, "A Chronology of Key Events," *Kenya Profile*, September 23, 2013, accessed February 1, 2014.

⁸⁶ Ibid.

⁸⁷ Ibid.

British colonists quickly won out. The railroad, which was completed in 1901, six years after construction began, changed the history of Kenya forever. The comparative ease of transportation into the nation's interior brought an influx of traders and explorers, exposing previously isolated Kenyan tribes to the world.

By 1920 the protectorate had become Kenya Crown Colony, a province administered by a royally-appointed white governor under the auspices of entirely British rule. Beginning after World War I, resistance movements to British rule began to grow in strength, as African natives protested high taxes, bans on traditional practices, low (if any) pay, and a lack of representation in colonial decision making.⁸⁸ World War II further contributed to the development of African nationalism, as many African servicemen hoped to take the independence they had gained as Allied soldiers back home with them.⁸⁹ As World War II ended, Kenyans began to unite for the cause of independence. In 1944, the Kenyan African Union was formed to campaign for independence, and three years later, Jomo Kenyatta, a well-educated Kenyan intellectual, became a leader of the organization.⁹⁰

Movements for independence reached a breaking point in 1952, when a Kenyan guerilla group called "Mau Mau" began to attack white settlers. Britain declared a state of emergency, responded violently to acts of rebellion, and threw Kenyatta into jail. Thousands of Africans were killed over the next few years, until the Mau Mau revolt was officially put out. Britain soon realized the futility of attempting to maintain a colony in Kenya, however, and announced plans for African rule in Kenya in 1960. In 1963, Kenya gained its independence, and Kenyatta was named prime minister.⁹¹

⁸⁸ Hallett, 61.

⁸⁹ BBC News, "A Chronology of Key Events," *Kenya Profile*, September 23, 2013, accessed February 1, 2014.

⁹⁰ Ibid.

⁹¹ Ibid.

After independence, Kenyan politics were anything but calm. Ethnic tensions and disagreements over who should rule permeated the discussion, and though Kenyatta remained in power until his death in 1978, his rule was not without challengers. Most elections held post-independence were criticized by the international community for human rights abuses and a near total lack of transparency on the part of the government.

Upon Kenyatta's death in 1978, Daniel arap Moi took the reins as the political leader of the Republic of Kenya. Moi's reign was marked by an increase in corruption and abuse in power, and his growing authoritarianism garnered international attention. In 1982, his government violently suppressed an attempted coup d'état by members of the Kenyan military. As the government spiraled out of control and into instability, the United States and other world powers began pressuring Moi to allow other political parties, to permit more freedoms for his citizens, and to end oppressive and violent attacks against ethnic minorities in Kenya.⁹² Though Moi had no choice but to acquiesce to most of these demands, his control over the media before and after the elections did not cease, and he won reelection in the 1990s and served until 2002 despite international protest.

In 1998, Nairobi fell victim to a terrorist attack carried out by Al-Qaeda under the direction of Osama bin Laden. During the morning rush hour of August 7th, a truck bomb exploded in downtown Nairobi, killing 224 and injuring more than 4,000. Despite the fact that the bomb targeted the U.S. embassy in Nairobi, the vast majority of the casualties—207 of the 224 killed and nearly all of those injured—were Kenyan civilians.⁹³ In videos broadcasted publicly after the attacks, bin Laden argued that the bombings were a terror attack in protest of the United States'

⁹² BBC News, "Wagella Massacre: Raila Odinga Orders Kenya Probe," February 15, 2011, accessed February 4, 2014.

⁹³ Brian Bennett, "Al Qaeda Operative Key to 1998 U.S. Embassy Bombings Killed in Somalia," *The Los Angeles Times*, June 12, 2011.

policy in the Middle East—specifically, the troops the U.S. had stationed in Saudi Arabia. The terrorist attack not only discouraged foreign investment in downtown Nairobi for some years afterward, it also was the first in a series of periodic, random terror attacks in Nairobi that continued throughout the beginning of the 21st century.⁹⁴ Recent examples of these attacks—which have increased in frequency since 2011—include several grenade attacks targeting civilians in 2011 and 2012 and the shooting at Nairobi’s Westgate Mall in September of 2013.⁹⁵

In the 2002 election, Moi sponsored Uhuru Kenyatta, Jomo Kenyatta’s son, as the presidential candidate for his party and his personal selection for president. Despite the support of the outgoing president, Uhuru Kenyatta lost badly at the polls, gaining less than 40 percent of the vote. Mwai Kibaki, the party candidate for the National Rainbow Coalition, won convincingly in an election that was considered by the international community to be fairer than those in 1992 and 1997.

The generally calmer political atmosphere in Kenya would not last, however. The 2007 elections pitted Mwai Kibaki’s incumbent regime—which had fallen greatly in popularity since 2002 as a result of associating too closely with Moi’s political policies—against Raila Odinga and the Luo-backed Orange Democratic Movement.⁹⁶ Again divided along tribal and ethnic lines,

⁹⁴ There are anecdotal reports that, following the bombing, foreign businesses were less willing to invest in infrastructure and position their offices in downtown Nairobi due to safety concerns. While it is difficult to verify if companies truly were skeptical of the safety of their employees and investments, the reports are well-supported by the fact that all major foreign powers, including the United States and the United Kingdom, moved their embassies out of the city’s center following the attacks into the more secluded and more easily protected suburbs of Nairobi.

⁹⁵ Jason Strazius, “Two Blasts in Nairobi Amid Fears of Terrorist Reprisal,” *The Associated Press*, October 25 2011; Edmund Blair, “Islamists Claim Gun Attack on Nairobi Mall, at Least 39 Dead,” *Reuters*, September 21, 2013.

⁹⁶ Tribal relations in Kenya are complex and dominate much of the social and political spheres of life. The Kikuyu tribe is the largest tribe in Kenya, comprising around 23 percent of the present-day population of Kenya. Kikuyus are often seen by both those in Kenya and by international observers as dominating Kenya’s culture, politics, and economy. Many of Kenya’s most successful politicians and businessmen have been Kikuyu. Kibaki is a Kikuyu, as was Jomo Kenyatta. The Luo tribe, of which Odinga is a member—generally distinguished by a surname that begins with O—is both smaller (third largest in Kenya at 13 percent) and poorer on average than those of the Kikuyu tribe. President Barack Obama and his father, Barack Obama, Sr., a prominent Kenyan economist, are both of Luo descent.

Kenya's population fell once more into violence.⁹⁷ The reports of pre-election violence in 2007 overshadowed the democratic process, with Reuters declaring the election "badly flawed."⁹⁸ After the election, Kibaki, the incumbent, was declared winner and was hastily sworn in at night. The resulting crisis consumed Kenya for several months. Non-Kikuyu Kenyans arranged a variety of protests against Kibaki's reelection, many of which were, at first, non-violent. Others quickly became riots, and police responded with brutal force, shooting hundreds of protestors, even on television. This unleashed a wave of ethnic violence against the Kikuyu—Kibaki's tribe—in Eldoret, Mombasa, and other cities across the country.⁹⁹ Eventually, Kofi Annan, the former Secretary General of the United Nations, arrived in Kenya and brought both sides to the negotiating table. The result was a coalition government that, while not perfect, managed to calm tensions enough that the violence could end.

Over the next five years, the coalition government imposed term limits on the president while severely cutting back the powers of that office. The coalition also created a new Kenyan constitution in 2010, which established a bill of rights for Kenyan citizens and transitioned some political power to local governments.¹⁰⁰ The political sphere during the latter part of the coalition government was relatively calm as a result of increasing compromise and legislative success and in 2013, Uhuru Kenyatta was elected president with 50.51 percent of the national vote in an election that was fairer and more peaceful than that in 2007.¹⁰¹

⁹⁷ Wangui Kanina, "Kenya's Election Seen As Badly Flawed," *Reuters*, September 18, 2008, accessed February 4, 2013.

⁹⁸ *Ibid.*

⁹⁹ *Ibid.*

¹⁰⁰ Jeffrey Gettleman, "Kenyans Approve New Constitution," *The New York Times*, August 5, 2010.

¹⁰¹ BBC News, "Kenya Supreme Court Upholds Uhuru Kenyatta Election Win," March 30, 2013; The 2013 election was not entirely without protest, however. The original election result was reviewed by the Supreme Court of Kenya, which ruled unanimously that the elections were free and fair and that the result should be upheld. Raila Odinga, Uhuru Kenyatta's challenger in the election, gained most of his support from non-Kikuyu ethnic groups, particularly the Luo, his own tribe. Though he followed through on his promise to respect the ruling of the Supreme Court, some of his supporters turned to violence following the result. The BBC reported in 2013 that two Odinga

Today, Kenya serves as a regional hub for many important international organizations and businesses, which are mostly located in Nairobi. These include the main headquarters for UN operations in Africa and the Middle East, as well as the United Nations Environmental Program and more than 100 major international companies. Despite international economic investments, however, Nairobi remains devastatingly poor in many parts, and is home to the first and third largest urban slums in Africa. Modernization is slowly arriving in Nairobi, and today, the majority of residents—regardless of income level—own cellular phones. As investments from companies in both China and the United States continue to improve Kenya’s infrastructure, more improvements in standard of living are expected.

Early History of HIV/AIDS in Kenya

The land upon which the Republic of Kenya is established has a longer human history than most nations on Earth, yet the most relevant portion of that history for the discussion that follows is only the past 30 years. According to AVERT, the earliest instances of HIV/AIDS in Kenya were between 1983 and 1985, when 26 cases of AIDS were reported.¹⁰² Sex workers in Kenya were among the first affected—a study from 1985 showed a 59 percent HIV prevalence rate among sex workers in Nairobi.¹⁰³ AVERT reports that cases increased throughout the mid-1980s until the nation averaged four new cases per month in 1986. By 1987, 286 cases had been reported, and 38 Kenyans had died as a result of AIDS.¹⁰⁴ That same year, different statistics showed that one to two percent of adults in Nairobi were living with HIV.¹⁰⁵

supporters were killed and eleven were injured. This pales in comparison, however, to the more than 1,200 people killed during the 2007-08 crisis.

¹⁰² AVERT, “HIV and AIDS in Kenya,” accessed February 4, 2014, www.avert.org/hiv-aids-kenya.htm.

¹⁰³ Ibid.

¹⁰⁴ Ibid.

¹⁰⁵ Ibid.

The virus' progress over the following years escalated rapidly, mostly as a result of the many factors listed above. In rural areas, a large portion of Kenyans were uncircumcised, and many dangerous traditional rituals—including female genital mutilation—were still widely practiced.¹⁰⁶ Wife inheritance—a traditional practice in which a widowed wife would be “inherited” by her deceased husband's brother—is suspected to have contributed greatly to the spread of HIV in rural areas of Kenya.¹⁰⁷ When men died of HIV, there was a very good chance they had unknowingly passed the virus on to their wife, who would then enter into a polygamous relationship with her brother-in-law and his wife, creating a cycle of death and transmission that allowed HIV to spread among extended families.¹⁰⁸

During the virus' rise, Kenyans with albinism—a pigment disorder of the skin that results in little to no color in the eyes, hair, or skin—were the victims of particularly bad oppression, due to the traditional belief that having intercourse with a person with albinism would cure one of HIV.¹⁰⁹ Others killed Kenyans with albinism in order to collect their body parts, which were used by practitioners of witchcraft in “magical concoctions.”¹¹⁰ Still others believed that having intercourse with a virgin would cure one of HIV.

Traditional religious and tribal practices were not alone in exacerbating the AIDS epidemic, however. Much misinformation existed about the disease in Kenya during the early years of the epidemic, as well—many Kenyans of the time did not even believe that HIV/AIDS

¹⁰⁶ Carole Inguru, interviewed July 4, 2013.

¹⁰⁷ Ibid..

¹⁰⁸ Traditional practices such as wife inheritance and female genital mutilation are difficult to quantify in terms of number of Kenyans who still practice. Mostly, these practices are found in rural areas, where data is more difficult to collect. It is widely accepted, however, that traditional practices are just that—traditional—and that they are becoming less and less common as education reaches rural areas of Kenya.

¹⁰⁹ Ibid.

¹¹⁰ Tom Odula, “10,000 Albinos in Hiding After Killings in East Africa,” *The Huffington Post*, November 28, 2009; IRIN, “Swaziland: Trade in Albino Body Parts Moving South,” *UN Office for the Coordination of Humanitarian Affairs*, August 25, 2010.

was real. Because the virus had such a long incubation period, and because its symptoms could vary so wildly, many thought that HIV/AIDS was an elaborate ruse to prevent Africans from having sex, and thus, from reproducing.¹¹¹ These various misconceptions about HIV/AIDS endangered the lives of thousands of people, and the government's inability and unwillingness to respond to misinformation about HIV/AIDS perpetuated the problem. Between 1989 and 1991, HIV prevalence among pregnant women in Nairobi increased from 6.5 percent to thirteen percent.¹¹² By 1994, more than 100,000 Kenyans had been killed by HIV/AIDS, and well over one million Kenyans were living with HIV—an estimated one in ten. By 1999, President Moi declared the epidemic a “national disaster.”¹¹³

Yet despite high rates of HIV, the early governmental response to HIV/AIDS in Kenya lacked urgency and effectiveness. The government received criticism from both those within and beyond the country's borders for failing to address AIDS adequately early on. While neighboring Uganda put millions of dollars towards HIV/AIDS awareness and prevention, Kenya contributed far less. In 1987, Kenya's Minister of Health used two million pounds donated by developed countries to fund a year-long health and education program, but little of Kenya's own resources and manpower were dedicated to addressing HIV/AIDS seriously. HIV/AIDS was not debated on the floor of the Kenyan parliament until 1993; that same year Naftali Agata, the director of the Health Ministry's program for AIDS prevention, told *The New York Times*: “We have not come out as fast as we should have in talking about AIDS.”¹¹⁴

¹¹¹ Inguru, July 4, 2013.

¹¹² M. Temmerman, et al., “Rapid Increase of Both HIV-1 Infection and Syphilis Among Pregnant Women in Nairobi, Kenya,” *AIDS* 6 no. 10 (1992): 1181-5.

¹¹³ AVERT, “HIV and AIDS in Kenya.”

¹¹⁴ Donatella Lorch, “After Years of Ignoring AIDS Epidemic, Kenya Has Begun Facing Up to It,” *The New York Times*, December 18, 1993.

Many of the complaints lodged against the Kenyan government were well founded. For much of its history, the Republic of Kenya has depended on tourism to support its people and economy. As a result, the government of Kenya was widely criticized for “playing down the threat of AIDS because of the damage it could do to Kenya’s tourism industry.”¹¹⁵ In his book, *From Crisis to Kairos: The Mission of the Church in the Time of HIV/AIDS, Refugees, and Poverty*, African theologian Rev. Agbonkhianmeghe E. Orobator, SJ, writes, “In Kenya, the official government response to the [HIV] epidemic followed a predictable pattern of denial, reluctant admission, and finally acceptance,” specifically citing Kenya’s tourism industry as a contributing factor to the poor response.¹¹⁶

Other criticisms were aimed directly at President Moi.¹¹⁷ In 1999, Moi addressed an AIDS awareness symposium, declaring the establishment of a National AIDS Control Council. Despite the step forward, critics pointed out that Moi failed to promote effective ways of preventing the spread of HIV in his speech, especially the use of condoms.¹¹⁸ He admitted that year to being “shy” about talking about condoms in public, and made questionable statements about how he hoped Kenyans could abstain from sex for two years.¹¹⁹ By the end of 1999, under increasing public pressure, Moi broke the silence on condoms in a speech to students at the University of Nairobi, saying, “The threat of AIDS has reached alarming proportions and must not be treated casually; in today’s world, condoms are a must.”¹²⁰ Despite this, HIV/AIDS prevalence in Kenya hit its peak—13.4 percent—in 2000.

¹¹⁵ AVERT. “HIV and AIDS in Kenya.”

¹¹⁶ Agbonkhianmeghe E. Orobator, *From Crisis to Kairos: The Mission of the Church in the Time of HIV/AIDS, Refugees, and Poverty* (Nairobi: Paulines Publications Africa, 2005), 90.

¹¹⁷ Tom Maliti, “Kenyan President Shy to Talk About Condoms as Hundreds Die Daily from AIDS-Related Illnesses Daily,” *The Associated Press*, July 16, 2001.

¹¹⁸ Ibid.

¹¹⁹ Ibid.

¹²⁰ Achieng, Judith, “President Moi Joins The Campaign Against HIV/AIDS,” *Inter Press Service*, December 3, 1999; AVERT. “HIV and AIDS in Kenya.”

In a joint report released by the Kenyan National AIDS Control Council (KNACC) and National AIDS and STI Control Programme (NASCOP) in 2011 that detailed the country's progress in HIV treatment and prevention, the two organizations summarized HIV's effects on Kenya quite succinctly:

Since Kenya recorded its first case of HIV in 1984, the AIDS epidemic has evolved to become one of the central impediments to national health, wellbeing and development. AIDS has deepened poverty; slowed economic growth; reduced life expectancy; worsened other infectious diseases; and visited particular ills on affected households, with the harshest effects experienced by women and children.¹²¹

Decreasing Prevalence

Eventually and reluctantly, the government began to take a serious stance on HIV/AIDS, and slowly but surely the prevalence rate started to fall. In a 2006 paper for the journal *Sexually Transmitted Infections*, Cheluget et al. analyzed this reversal of prevalence rates and determined several factors that may have contributed to the trend.¹²²

Using census data collected through the Kenyan Demographic and Health Surveys in 1993, 1998, and 2003, Cheluget et al. found that sexual behavior over those years changed significantly in directions that would help prevent the spread of HIV. Specifically, the researchers found that age at first sex increased by more than a year on average from 1993 through 2003, whereas the percentage of men and women with more than one sex partner in the last year and the percentage who reported being sexually active in the last four weeks both dropped.¹²³ In addition, the prevalence of women participating in polygamous unions dropped, a decline which the researchers

¹²¹ National AIDS Control Council (NACC) and National AIDS and STI Control Programme (NASCOP), "Kenya AIDS Epidemic Update 2011," 2012.

¹²² B. Cheluget, et al., "Evidence for Population Level Declines in Adult HIV Prevalence in Kenya," *Sexually Transmitted Infections* 82 no. 1 (2006): i21-i26.

¹²³ Ibid.

argue also may have contributed to reductions in HIV prevalence.¹²⁴ Cheluget et al. also found similarities between the HIV prevalence rate decline in Kenya and the same decline that occurred in Uganda several years earlier. They explained this disparity in time, writing: “recognition of the problem of AIDS arose later in Kenya and the involvement of the government, community groups, and the church has lagged.”¹²⁵

This behavior change came about as a result of several factors. First, young people who were aware of HIV/AIDS and the ways in which it could be transmitted were often scared to have casual sex, and therefore thought more carefully before engaging in risky behavior. Secondly, advertising campaigns sponsored by NGOs and the Kenyan government, which will be discussed more fully below, contributed significantly to increasing public awareness of HIV and its associated dangers. Thirdly, increasing formal education throughout the early part of the 21st century among young Kenyans provided them with a better understanding of the disease and its effects.¹²⁶

In their paper, Cheluget, et al. applauded the approval of condoms on behalf of both the government and Kenyan society, writing that “condom promotion has always been strong in Kenya.”¹²⁷ While this conflicts with the criticism of Moi’s attitude towards condoms in the late 1990s, the researchers argue that Kenya quickly turned around on the condom question and made sure the public was aware of their preventative effects. In addition, Cheluget et al. cite the increasing use of voluntary testing and counselling services (VTCs) (used by 200,000 people in 2003) and services to prevent transmission of HIV from mother to child during pregnancy and

¹²⁴ Ibid.

¹²⁵ Ibid.

¹²⁶ Inguru, July 4, 2013.

¹²⁷ Cheluget, et al.

birth (used by 120,000 pregnant women).¹²⁸ The increase in antiretroviral therapy (ART) among HIV positive Kenyans also increased in the early 2000s as a result of increased international aid, reaching at least 20,000 people by 2006.¹²⁹

Unfortunately, one of the most significant statistics for decreasing HIV prevalence in Kenya during the 2000s was the massive number of deaths suffered each year as a result of the virus:

The decline is occurring partly because deaths due to AIDS have reached very high levels, around 130,000 per year, as a result of high incidence in the mid-1990s. Thus about 10% of infected adults are dying each year. New infections are adding about 6%, or 80,000 people to the infected population each year. Before 2000 there were still more new infections than deaths, but since 2000 the situation has reversed.¹³⁰

As deaths due to HIV increased, the virus' prevalence among the living Kenyan population decreased faster than new infections could appear. As ART became more widespread in the years after 2006, however, deaths due to HIV began falling rapidly.

HIV prevalence fell during the later 1990s and early 2000s for several other reasons, as well. One was the government's strong commitment to voluntary male circumcision. In the KNACC and NASCOP report from 2011, the two groups reported that Kenya performed more than 230,000 voluntary circumcision procedures from 2008 to 2010, "reaching more than 60% of previously uncircumcised adult males in Nyanza Province, where circumcision prevalence is much lower than the national average."¹³¹ Whereas de Sousa et al. previously reported relatively low rates of circumcision among Kenyans during the 1960s and '70s, increasing male circumcision in

¹²⁸ Ibid.

¹²⁹ Ibid.

¹³⁰ Ibid.

¹³¹ NACC and NASCOP, "Kenya AIDS Epidemic Update 2011."; Centers for Disease Control and Prevention, "Progress in Voluntary Medical Male Circumcision Service Provision," *Morbidity and Mortality Weekly Report*, November 30, 2012; Zebedee Mwandu, "Voluntary Medical Male Circumcision: Translating Research into the Rapid Expansion of Services in Kenya, 2008-2011," *Public Library of Science*, November 29, 2011.

Kenya during the earlier years of the HIV/AIDS epidemic likely decreased transmission. Large scale awareness advertising programs during the 1990s and early 2000s further contributed to declining rates of HIV in Kenya by providing education on routes of transmission and effective ways of avoiding infection.

HIV/AIDS Statistics in Kenya Today

Overall HIV prevalence has declined in Kenya since 2000, though tens of thousands continue to die each year as a result of AIDS. HIV prevalence among adults began falling earlier, in the mid to late 1990s. Figure 3, provided by the KNACC and NASCOP, charts Kenya's progress on HIV, and shows the decrease in HIV prevalence discussed in the section above.

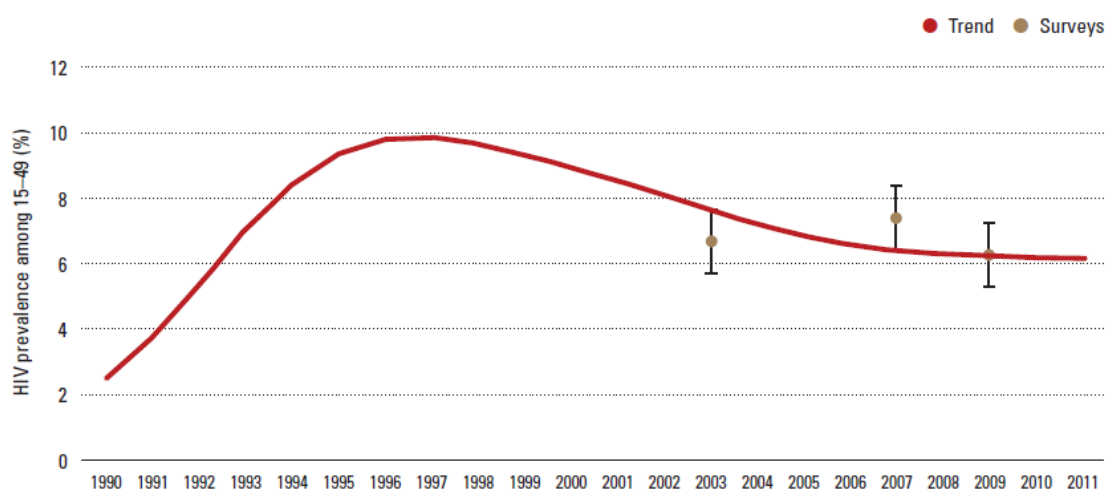


Figure 3. HIV prevalence in Kenya.¹³²

These statistics have been a cause for great optimism among Kenyan citizens and the Kenyan government. The data imply that interventions are working, that the population is becoming more educated about HIV/AIDS, and that the virus is being steadily defeated. With an optimistic tone, a 2011 report from KNACC reads:

¹³² NACC and NASCOP, "Kenya AIDS Epidemic Update 2011."

National HIV prevalence has markedly declined over the last decade; unprecedented levels of financing have been mobilized to support evidence-based efforts to address AIDS; effective treatments that were once out of reach are being brought to scale; notable changes in sexual behaviours have slowed the rate of new infections, especially among young people; and tangible progress has been achieved towards the ultimate goal of eliminating mother-to-child HIV transmission.¹³³

Though this progress is promising, KNACC also warns of the need for “constant vigilance.” There are still more than 1.8 million people living with HIV/AIDS in Kenya, and the increasing distribution of ARTs has only allowed that number to increase. As medication becomes more effective and more widely distributed, the number of people living with HIV/AIDS in Kenya will likely increase. Figure 4 illustrates how ARTs, which were introduced in large numbers in the mid-2000s with the help of USAID and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), have actually increased the number of people living with HIV/AIDS in Kenya. The initial decrease (beginning around 1997) in the number of people living with AIDS is a result of the massive death rate from the virus around that time. As ARTs were introduced, the number steadily climbed, and continues to climb today.

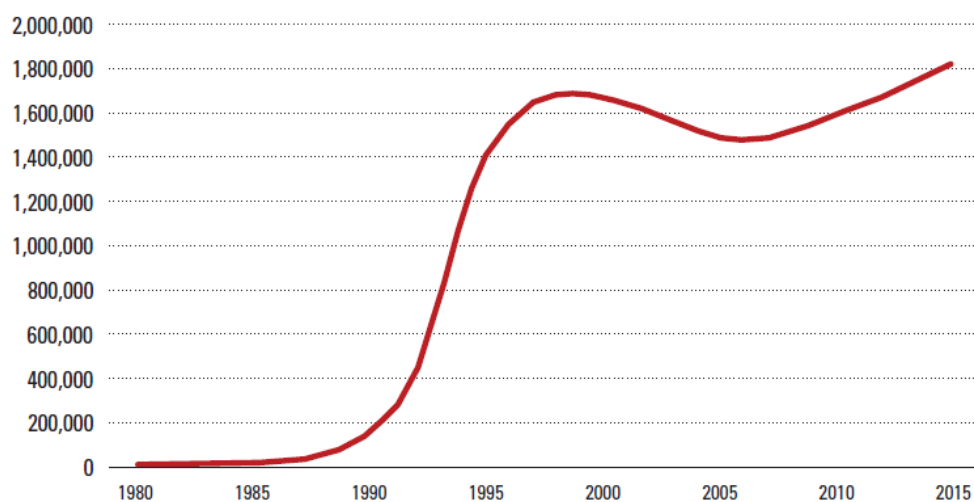


Figure 4. Number of children and adults living with HIV in Kenya.¹³⁴

¹³³ Ibid.

¹³⁴ Ibid.

While Figure 4 speaks to the success of ARTs in prolonging the lives of those living with HIV/AIDS, it almost implies, upon first inspection, that these medications actually result in more new infections. They do not. Further data provided by the KNACC and NASCOP (Figure 5) confirms that new infections of HIV in Kenya spiked around 1993, and have remained relatively stable in the years since.

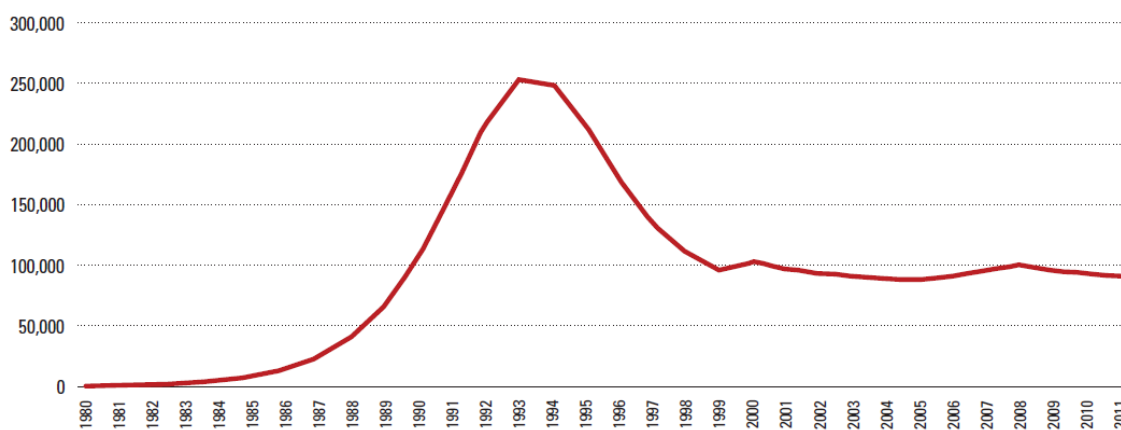


Figure 5. New HIV infections among adults in Kenya.¹³⁵

Kenya, like much of sub-Saharan Africa, has been disproportionately affected by HIV/AIDS in such a massive way that its history has forever been changed by the epidemic. We have now traveled from the earliest days of HIV/AIDS, to the damage it has done in Kenya, both directly and indirectly, all the way up to the present day. As KNACC and NASCOP note, the effects of HIV/AIDS on Kenyan society range from the obvious: sickness and death; to the closely related: poverty and disability; to the distant yet still connected: instability, violence, and economic stagnation. As the following section points out, each of these effects continues to be intimately connected to HIV/AIDS, and each is closely related to the creation of an AIDS-free future.

¹³⁵ Ibid.

CHAPTER THREE

Current Responses to the Epidemic in Kenya

Having set the historical stage for the fight against HIV/AIDS in Kenya, we can now begin to discuss the nation's current attitude towards HIV/AIDS, while keeping in mind the historical precedents discussed above. These precedents are particularly relevant as precursors of today's attitude towards HIV/AIDS among Kenyans, and, in many cases, as impediments to education. What this chapter primarily analyzes, however, is not statistics of HIV infection or prevention. Rather, it discusses what education on HIV/AIDS looks like in Kenya today, both formally and informally. Through the work of the government, the Catholic Church, and hundreds of NGOs, the fight against HIV/AIDS in Kenya today remains very winnable, in large part because

so many people know so much more about HIV/AIDS than they did previously. This chapter will discuss many of the reasons for this shift in specific detail.

State Sponsored Education

Education is often put forth as a one-step solution for the world's problems. If a population is better educated, the individuals in that population will be more economically productive, will make healthier decisions that benefit both themselves and their society, and will be less prone to violence. Each of these claims is, to some extent, supported by data, though it is clear that education cannot accomplish these tasks alone. Education is not a cure-all and cannot singlehandedly bring about the defeat of HIV/AIDS—but it certainly helps in the fight. Today, HIV/AIDS rightfully maintains a prominent place in Kenyan education, as the following few sections show.

Education systems in Kenya today are highly similar to those in the United Kingdom, a remnant of colonial influence. Students begin primary school at age six or seven, after a year of kindergarten, and stay until they are around fourteen. Primary education lasts eight “standards,” from standard one to standard eight. At the end of primary school, students sit for the Kenya Certificate of Primary Education (KCPE), a standardized exam that evaluates their comprehension of the material to that point and qualifies them for entrance into secondary school.¹³⁶ Primary

¹³⁶ According to the students and teachers at St. Aloysius, the KCPE is extremely important and is not always taken as seriously as it should be. In many cases, a student's future is decided by their KCPE exam score, which they take when they are just twelve or thirteen years old. If the score is high enough, a student might be able to receive a scholarship to a secondary school; if it is not, their education might end right after primary school. Because primary school is free and public, primary school teachers do not have much incentive to produce students that will score well on the exam—they have no need to attract students like private schools do. There are other difficulties with the KCPE, as well. One student at St. Aloysius told me a story about his cousin, who he said was a very good student throughout his primary school years, performing at the top of his class. He was expected to do well on the KCPE and receive a scholarship that would allow him to attend secondary school and later go on to university, where he hoped to study to be a doctor. One week before the KCPE exam began, however, he fell ill with malaria. The intense fever and weakness brought on by the disease caused him to score extremely poorly on the exam. Because of the

education was made free and universal, but not compulsory, by President Moi in January 2003, a policy which had previously existed in the 1980s but was ended during government spending cuts in the 1990s.¹³⁷

Upon leaving primary school, many students drop out due to poor test performance and find unskilled jobs. Those that continue in education go to one of three types of schools—government-funded, private, or harambee.¹³⁸ Harambee schools generally accept students with lower scores, while government schools select students in order based on KCPE test performance. Those students who qualify and are selected (or who have the ability to pay higher fees) can attend private secondary schools. Though the Kenyan government unveiled plans to make secondary education free in 2008, they have not yet been completely achieved.¹³⁹

Secondary school lasts four years—form one to form four—and allows students greater specialization in subject matter, much like high school in the United States. At the end of secondary school, students sit for the month-long Kenya Certificate of Secondary Education (KCSE) exam, which evaluates performance by students for potential attendance at universities. Those that score well receive government-funded scholarships to universities around Kenya, while those who score lower can attend two-year colleges or technical schools.

Regardless of a secondary school's affiliation, much of the curriculum is dictated by the government's Ministry of Education. Each year, the ministry publishes textbooks in all common disciplines, which include geography, history, mathematics, biology, chemistry, physics, English,

rigid and standardized nature of the test, he could not reschedule and he could not delay. As a result, his KCPE score was far lower than he expected, and he ended up attending a harambee school rather than receiving a scholarship to the secondary school he had hoped to go to.

¹³⁷ BBC News, "Free Secondary Schools for Kenya," February 11, 2008.

¹³⁸ Harambee, roughly translated from Swahili, means "working together for a common purpose" or "all pull together." Literally translated, the word means "synergy," but this fails to get at the more unitive meaning behind the phrase.

¹³⁹ BBC News, "Free Secondary Schools for Kenya."

French, and Kiswahili. These books are used in all secondary schools, but can be supplemented by additional approved materials provided by teachers.

Much of the official, state-sanctioned health information that is relevant to a discussion of HIV/AIDS education is provided to students in biology classes. The official curriculum of the Kenyan Ministry of Education provides several pages on STIs, with much of the material dedicated specifically to HIV. The material provides details of AIDS and HIV, including the various modes of transmission. The book goes on to list several ways in which one can avoid contracting HIV, which include “avoidance of indiscriminate sex” and “avoidance of situations that expose you to high risk of infection, such as excessive intake of alcohol, drug addiction, some cultural practices like wife inheritance, female genital mutilation, and traditional circumcision.”¹⁴⁰ In addition, the official textbooks encourage readers to make use of VTCs, and explain in detail the effect and effectiveness of antiretroviral medications.

In addition to providing correct information about HIV/AIDS, the official Ministry of Education textbooks also directly address common misconceptions about HIV/AIDS. The textbook for Form Two (sophomore secondary school) students states clearly that HIV/AIDS cannot be spread by casual contact or through air, and goes on to say that ARTs are not cures for HIV/AIDS, but can only “prolong the life of infected individuals.”¹⁴¹

While the information in these textbooks is correct and accessible for the age group to which it is taught, there are some serious shortcomings in the material. For example, HIV is listed among various other STIs, including hepatitis, syphilis, and herpes. While these other infections are dangerous in and of themselves, the exceptionalism of HIV/AIDS should be acknowledged more in the textbooks, specifically because HIV/AIDS is exceptional and poses a much greater

¹⁴⁰ Kenyan Ministry of Education, “Form Two: Biology,” 2011, 125-7.

¹⁴¹ Ibid.

danger to the Kenyan population than other STIs. Without doing so—and particularly if the teacher is not engaging or competent—information about the spread of HIV/AIDS becomes just another series of facts that fifteen-year-old students need to memorize.

At the same time, however, institutional education in Kenya about HIV/AIDS clearly works. As a result of primary education on HIV/AIDS, nearly all secondary school students can quickly list off the ABCs of HIV/AIDS prevention—abstinence, be faithful, use condoms—as well as the ways in which the virus is passed from person to person. As the students get older, the curriculum gets deeper and more technical, and they learn more about the biology of HIV as a virus, which gives greater context to the disease. In secondary school, they even discuss the effects of the virus on their country's society and culture, and the ways in which it disproportionately affects certain populations.¹⁴²

In Kenya, expansion of free education from just primary school to include secondary school would have positive effects on the nation's education level as a whole and could help to continue the decrease in HIV prevalence levels that Kenya has already seen. While this change would come at a cost, it is a cost that Kenya should be willing to bear. Just last year, Uhuru Kenyatta made a promise to provide a laptop to every schoolchild in Kenya.¹⁴³ The move was widely protested by teachers and school principals, who argued that it was wasteful to provide students with laptops that they could not safely bring home or use outside of the school.¹⁴⁴ Rather

¹⁴² Ibid.

¹⁴³ Joab Apollo, "Uhuru Kenyatta Promises Free Laptops for All Kenyan Schoolchildren," *The Guardian*, April 10, 2013.

¹⁴⁴ While I was in Kenya in the summer of 2013, the primary school teachers throughout the country went on strike, in part because of this program to buy laptops for every student. The teachers argued that they were not being compensated fairly, and that the rapidly growing population combined with free primary school education was resulting in classes of 80 or 100 students to a single teacher. The laptop program, in a way, was the straw that broke the camel's back. To the government, laptops for all students would be a sign of progress and technological advancement for a country that is considered by the global community to be undeveloped. To the teachers, it showed how little the government understood the realities of daily school life for children in Kenya's poorest areas. To them, the project was wasteful and missed the mark of the biggest problems facing Kenya's public education

than spending on excessive programs like this, the Kenyan government should instead invest in improving access to education across the nation.

Though it took some time for the Kenyan government to admit publicly that the nation was facing a significant problem with HIV/AIDS, once they finally did so, change came relatively quickly. The sudden onset of millions of HIV positive people forced the government to acknowledge HIV/AIDS whether they wanted to or not, and state-sponsored education was an initial target for international aid intended to mitigate the problems of HIV/AIDS. As a result, Kenyan curricula quickly adopted correct, in-depth information on HIV/AIDS, likely saving thousands of lives as a result.

AHAPPY Generation

Although the Ministry of Education's material on HIV/AIDS has been effective in educating young people on the specifics of HIV/AIDS, it fails to integrate scientific and biological information with any sort of life skills or holistic education. Students are provided with specific circumstances that they are told are risky behaviors, and are, in essence, scared out of engaging in behavior that might lead to infection by HIV. While this is sometimes effective, it is clear that it is not the most comprehensive way of addressing the problem.

system—crowded schools and overwhelmed, underpaid teachers. Just before I left St. Aloysius to return to the United States, the teachers there (who did not strike, because the school is private) had a meeting in which they discussed obtaining e-readers for the students. These would allow students to store textbooks and other materials, which they could download using wireless internet at the school and access either at home or at school, without the need for wireless internet. During that meeting, the teachers argued—convincingly—that providing e-readers for every student would be a far better investment than providing laptops. In part, this is because e-readers are less expensive than laptops—the e-readers for St. Aloysius, for example, were only 20 to 30 percent of the price of the laptops the government was planning on buying. At the same time, e-readers are smaller, and thus easier to transport, protect, and keep safe. They also need charging less often. Students at St. Aloysius received their e-readers in the spring of 2014—according to teachers, the program has been successful so far.

In 2013, the African Jesuit AIDS Network (AJAN) responded to what it saw as a need for comprehensive, life skills, HIV/AIDS-based education, and released a brand-new curriculum for teaching about HIV/AIDS in schools and in small group settings. The organization called it AJAN HIV/AIDS Prevention Program for Youth (AHAPPY Generation), with the intention of educating and empowering young people to become the first HIV/AIDS-free generation. In developing the curriculum, AJAN, a network of Jesuit priests working in Africa specifically with the problem of HIV/AIDS, drew on the experiences of its membership to create an engaging and culturally specific set of lessons that addressed issues of sexuality, STIs, and safe sex for young people.

Currently, the AHAPPY curriculum has been piloted at schools in seven different countries in Africa, including St. Aloysius Gonzaga Secondary School in Nairobi, Kenya, and schools in the Central African Republic, Zimbabwe, Nigeria, and Benin. According to the director of AJAN, Pat Mombe, SJ, the need for the curriculum grew out of a desire to educate the whole person, rather than simply provide information on HIV/AIDS transmission statistics and preventative measures. In an interview, he made this argument clear:

It's not all about filling the head with information, but putting it in such a way that bridges the gap between knowledge and behavior. It's not enough to know just about the disease. There are other things to learn here... We try to look at the approach not as sexual education, but as human growth education, by taking all of the dimensions and nourishing them in a balanced way.¹⁴⁵

As such, the AHAPPY curriculum centers on five modules—be attentive, be intelligent, be reasonable, be responsible, and be proactive.¹⁴⁶ The book begins with a broad view of the world, leaving HIV/AIDS until later chapters. It first asks students to consider what it means to live the right way, and how decisions one makes can affect one's neighbors. Being produced by a religious

¹⁴⁵ Pat Mombe, interviewed July 1, 2013.

¹⁴⁶ African Jesuit AIDS Network, *AJAN HIV & AIDS Prevention Program for the Youth (AHAPPY Generation): Promoting Integral Development of Young People* (Nairobi: Ascent, 2012).

organization in a part of the world that is largely Christian and “notoriously religious,” the curriculum does not attempt to appear secular.¹⁴⁷ It asks students in early chapters to consider how the world would look “the way God wants it,” and compare that to how they see the world today. According to Samuel Ebale, one of the curriculum directors for AJAN, the early chapters are an attempt to empower young people to make their own decisions, stand above peer pressure, and be assertive in their choices. Reflection journals at the end of each chapter—which Ebale called “very Ignatian”—encourage self-reflection on the part of the students.¹⁴⁸

When AIDS is addressed in later chapters, the AHAPPY curriculum has already established the dignity of the student and helped them to consider their place in the world and the magnitude of their decisions, which Mombe says allows a deeper and more effective discussion of HIV/AIDS. As opposed to other AIDS curriculum—for example, the information published by the Kenyan Ministry of Education or Population Services International (PSI)—Ebale, Mombe, and Carole Inguru, another curriculum director, all argue that AHAPPY’s approach is more holistic and effective.¹⁴⁹ Unlike these other curricula, AHAPPY avoids using scare tactics to discourage risky behavior, and does not focus solely on HIV/AIDS.¹⁵⁰

Based on the content of the AHAPPY book distributed to students, their claims appear to have merit.¹⁵¹ Not only does the AHAPPY curriculum include all of the relevant scientific information and data—including transmission modes and risk, effective preventative measures (including condoms), the symptoms and effects of HIV/AIDS and other widespread STIs, and

¹⁴⁷ Richard Rwiza, interviewed July 2, 2013.

¹⁴⁸ Samuel Ebale, interviewed July 23, 2013.

¹⁴⁹ PSI is a non-governmental organization that works to address public health issues in the developing world. It will be discussed at greater length in the following section.

¹⁵⁰ It is important to note, however, that unlike the Ministry of Education’s material, AHAPPY clearly points out that HIV/AIDS—while technically an STI like any other—is exceptionally dangerous and prevalent. This ensures that students leave the program with a sufficiently broad understanding of STIs in general, but also with the knowledge that HIV/AIDS is a particularly large challenge for Kenya and the world.

¹⁵¹ AJAN, *AHAPPY Generation*.

statistics on HIV/AIDS in Kenya—the book also includes more intangible aspects of the problems associated with HIV/AIDS, such as discussions of stigma, peer-pressure, prudent decision making, and other life skills like independence, assertiveness, and empowerment.¹⁵² In class discussions, these topics allow students who otherwise might not have the opportunity to speak freely about problems they are facing at school, at home, or among their friends. The curriculum is specifically intended for small groups of ten or fewer students with one facilitator, usually a teacher. The small group setting encourages a “community feeling” that the developers of the curriculum claim allows a support system to develop outside of a traditional classroom or familial structure.¹⁵³

In observing and participating in AHAPPY classes at St. Aloysius Gonzaga Secondary School, this final claim appears to have significant merit. Students at St. Al’s meet with their AHAPPY groups once each week on Monday afternoons. Every week, the meetings occur with the same teacher, and the same group of students, for all four years of secondary school. The groups are mixed-gender, but all of the students are from the same age group, making discussions of sex and sexuality less awkward than they may be if some students were significantly older. The result is a close group of friends who can speak openly and frankly with each other, acting as a crucial support system in the lives of orphans who so often lack a supportive family structure.

Teachers who lead the AHAPPY groups also speak to the merits of the curriculum. Beatrice Maina, who served as principal of St. Aloysius until the end of 2013, spoke particularly highly of AHAPPY’s ability to bring students and teachers into closer relationships with one another.¹⁵⁴ She pointed out that AHAPPY removes teachers from the pedestal upon which they are so often placed

¹⁵² Ibid.

¹⁵³ Ebale, July 23, 2013.

¹⁵⁴ Beatrice Maina, interviewed July 18, 2013.

in classrooms, and allows them to enter into a more meaningful discussion with their students about issues that go far beyond the walls of their classroom.¹⁵⁵

Previous HIV/AIDS and sex education curricula at St. Al's relied on the use of "peer facilitators"—older students who were deemed to be mature and responsible—to organize and run the group sessions. This had several negative effects, including an unwillingness on the part of younger students to share their concerns and feelings, and a less serious and meaningful attitude. According to Maina, most of this curriculum, which was designed by Kenya's Ministry of Health, was very information-based and did little to educate students on how to make good decisions.¹⁵⁶

AHAPPY, on the other hand, allows teachers to enter into counseling and supportive relationships with students. If concerns arise, they can bring them to the attention of the school's social worker, or otherwise address the students' needs themselves. Because of this increased responsibility on the part of teachers, however, significant training was required to ensure that they would be able to handle the demand. AJAN ran several training sessions for teachers, in which they first experienced the material as a student, with a curriculum director moderating the discussion. This allowed the teachers not only to encounter all of the material that they would later be teaching, but also to understand the dynamics of a group discussion on topics that are uncomfortable to speak openly about.¹⁵⁷

Eventually, AJAN hopes to expand AHAPPY to additional Catholic or religious based schools across Africa. The material, according to Inguru, is not just for schools, however. It can also be used in various AIDS-prevention clubs that have cropped up among young people across Africa, in church youth groups, and even just among families who want to educate their children.

¹⁵⁵ Ibid.

¹⁵⁶ Ibid.

¹⁵⁷ Ibid.

Though it derives significant inspiration from St. Ignatius of Loyola and his spirituality, the material is not necessarily religious, and could also find application in secular schools and organizations, according to Mombe.¹⁵⁸

Despite its early success and growing support, AHAPPY is not without its shortcomings. One huge shortcoming in the case of St. Aloysius, for example, is the inability of the program to involve the parents and guardians of the students. Maina pointed out that, although students may gain a significant amount of knowledge about HIV transmission and the virus' effects in school, they often will return home at the end of the day to different information from their parents or guardians. This disconnect can prevent retention of the material, and perpetuate misinformation about HIV/AIDS and other STIs. According to Maina, many adults exacerbate the problem by being ashamed of their own lack of knowledge, lashing out at their children or refusing to discuss with them what they have learned.¹⁵⁹

AHAPPY and its pilot schools have attempted to address this problem by having parent-child sessions approximately once per month, where students can bring their parents or guardians to AHAPPY class. The hope with these sessions is to open up parents and guardians to discussing uncomfortable topics with their children, which in turn can lead to an easier exchange of knowledge and better decision making. Unfortunately, these programs have, in general, seen poor attendance. Many parents and guardians at St. Aloysius, for example, cannot take time off of the many jobs they are working to attend class. In other cases, parents or guardians simply do not care. Because St. Al's is a school for orphans, most of the children live not with their own family, but with guardians who have offered to shelter them. These guardians, according to Maina, do not

¹⁵⁸ Mombe, July 1, 2013.

¹⁵⁹ Maina, July 18, 2013.

always take on the full responsibility of parenting, and as a result, attendance by adults at AHAPPY meetings is not reliable.¹⁶⁰

Much as AHAPPY has difficulty reaching parents and guardians, it also will likely have difficulty reaching rural areas. Though AJAN has not yet attempted to expand the program to rural areas, both Inguru and Mombe admitted that the curriculum is better suited for urban environments, where Kenyans regularly attend schools and have more organized schedules and lifestyles.¹⁶¹ Because the AHAPPY program is so dependent on a small group that meets regularly with a single facilitator, it will be more difficult to apply to rural communities, where Kenyans are more nomadic and live less structured lives. The curriculum directors attempted to mitigate this disconnect in two ways. First, by making the book as easy to understand as possible, with large print, pictures, and simple language. This not only allows children to understand its contents more clearly, but also makes the information more accessible to young adults who have not received much education. Secondly, they made sure that the book provides adequate background information so that it can be effective even in the hands of someone who has never been exposed to what STIs and HIV are.

Another potential criticism that can be lodged against the AHAPPY program is its stance on condoms. As a society of the Roman Catholic Church, the Jesuits as an institution uphold official church teaching on condoms, expressed in particular in *Humanae Vitae*, which technically prohibits all forms of artificial contraception.¹⁶² This type of attitude is often considered dangerous in areas of the world where HIV/AIDS is prevalent, because it can, in theory, lead to a lower availability of condoms, more unsafe sex, and higher rates of transmission of HIV.

¹⁶⁰ Maina, July 18, 2013.

¹⁶¹ Mombe, July 1, 2013; Inguru, July 4, 2013.

¹⁶² Paul VI. *Humanae Vitae*. July 25, 1968, http://www.vatican.va/holy_father/paul_vi/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae_en.html.

Luckily, in the case of AHAPPY, this criticism does not hold water. The AHAPPY manual that is given to students specifically cites condoms as being one of the most effective means of preventing transmission of HIV if one chooses to have sex, but stresses, correctly, that abstinence remains the most effective way of avoiding contracting HIV. Mombe addressed this concern directly, pointing out that the AHAPPY book presents “the right and full information,” but does not advocate for condoms as an acceptable solution to the problem of HIV/AIDS.¹⁶³ Carole Inguru said the same, arguing “you can’t put a condom on your heart”—that the effects of sexual intercourse among young people often go far beyond the biological.¹⁶⁴ Taken as a whole, from an objective standpoint, the AHAPPY curriculum does provide the full and correct information about condoms and their effectiveness in preventing the spread of HIV, but in general discourages pre-marital, casual sex—thus, in the eyes of the authors, discouraging the need for condoms at all.

It is too early to tell how AHAPPY has affected the spread of HIV/AIDS, or how it will affect it in the future. As the program expands from pilot schools to more widespread implementation, more data will be available on how well the program addresses the problem of HIV and AIDS in Africa. Despite relatively minor shortcomings, AHAPPY is a revolutionary way of approaching HIV/AIDS education, pioneered by an historically respected educational organization—the Jesuits.

Mombe points out that the “work of education is to be undertaken constantly.”¹⁶⁵ By addressing issues at play beyond just HIV/AIDS and its routes of transmission and by building deeper relationships between students and teachers, AHAPPY undertakes this education in all areas of a student’s life. Having seen firsthand the implementation of AHAPPY curriculum, its

¹⁶³ Mombe, July 1, 2013.

¹⁶⁴ Inguru, July 4, 2013.

¹⁶⁵ Mombe, July 1, 2013.

overwhelmingly positive effects are obvious. In a part of the world that is wildly unstable, AHAPPY acts as a foundation for students at St. Aloysius, bringing them relevant and crucial information for their own health while contributing directly to their self-esteem, self-understanding, and personal growth and development as young people.

Social Advertising

HIV/AIDS education is not left solely in school, however. Just as the virus has permeated so much of Kenyan culture, education about HIV and AIDS has, as well. Even today, despite decreases in funding for HIV/AIDS awareness programs, it is difficult to walk through Nairobi without quickly seeing a traditional advertisement—either on a billboard, painted on a wall, or in a newspaper—that addresses HIV/AIDS. Many of the matatus—van-like buses that dangerously speed through Nairobi’s narrow streets—bear slogans like “Spread Gospel, Not Virus.” During the height of the epidemic, these advertisements were even more prevalent than they are today.

Carole Inguru pointed to a series of advertisements about HIV/AIDS sponsored by Population Services International (PSI) as being particularly effective in getting the word out on HIV/AIDS in the ’90s and early 2000s.¹⁶⁶ PSI is an international non-governmental organization (NGO) that works to address issues of public health in the developing world, and uses funding from both the United States Agency for International Development (USAID) and the United Kingdom’s Department for International Development (UKAID) to “contribute to the reduction of HIV incidence in Kenya,” through its Kenya-specific division, PSI/Kenya.¹⁶⁷

In addition to television and traditional billboard and print advertisements, PSI/Kenya also produced the first “edutainment” TV drama series, *Siri*, to encourage behavior that limited the

¹⁶⁶ Inguru, July 4, 2013.

¹⁶⁷ PSI/Kenya, “Improving Health in Kenya,” *Population Services International*, accessed February 5, 2014.

spread of HIV/AIDS and educated the public on the dangers of unsafe sex and other risky behaviors. According to a later review conducted by Stephen Aloo, *Siri* had a variety of intentions:

[SIRI] addressed essential messages about key HIV and reproductive health issues that the Ministry of Health had identified as essential to address in its communication strategy. These messages included promotion of HIV Counseling and Testing, Prevention of Mother to Child Transmission, Sexual Gender Based Violence services and promotion of Family Planning. The communication targeted men and women of reproductive age in urban and rural areas. The multi-media communication aptly named SIRI was informed by the need to create an entertaining but educative communication campaign that focuses on the universe of women engaging and sharing their secrets and getting enlightened so that they can make informed choices regarding reproductive health with the support from their male partners. The campaign sought to address societal and individual challenges like stigma around HTC [HIV Testing and Counseling], PMTCT [Prevention of Mother to Child Transmission] and family planning by empowering women to make informed decisions.¹⁶⁸

“Siri,” which means “secret” in Swahili, began its run in the mid-2000s and quickly became popular among Kenyans for both its education and entertainment value. It was revolutionary in that it combined the popular entertainment aspects of soap operas that many Kenyans love with the information on HIV, healthy relationships, and gender inequality that they needed to hear. Inguru argued that it was one of the most effective ways to reach Kenyans during the height of its popularity, and remains relevant today.¹⁶⁹

While a soap opera on HIV/AIDS might seem unusual to a Western observer, Kenya’s response to HIV/AIDS truly entered all areas of life. The Kenya Scouts Association, a member of the World Organization of the Scouting Movement, began offering an HIV and AIDS badge—the Red Ribbon Badge—to young men and women in the mid-2000s. Using the support system and informally educational nature of the scouting movement, UNAIDS, which funds the badge

¹⁶⁸ Stephen Aloo, “Kenya (2011): Evaluation of the ‘Siri’ Edutainment Television Series on Promoting Behaviour Change Among Men and Women in Kenya,” *Population Services International*, May 20, 2011.

¹⁶⁹ Inguru, July 4, 2013.

program, has been able to get comprehensive information on HIV/AIDS and prevention methods directly to the young people who need the information most.¹⁷⁰

Government Interventions

As the above section noted, the response of the Kenyan government to HIV/AIDS was delayed and ineffective at first. Upon realizing the disastrous nature of the epidemic, however, attitudes quickly changed. One of the most prominent advancements in the fight against HIV/AIDS in Kenya occurred in 2006, when the government enacted the HIV and AIDS Prevention and Control Act. The law protects the rights of those living with HIV by prohibiting mandatory testing and discrimination on the basis of HIV status.¹⁷¹

Although these laws remain difficult to enforce, as all discrimination laws do, they exemplify a significant shift in the attitude towards people living with HIV/AIDS. In the early years of the epidemic, it was not uncommon for countries to have laws prohibiting people living with AIDS to exit or enter the country. Though it came late, the HIV and AIDS Prevention and Control Act remains highly relevant to the Kenyan government's attitude towards HIV/AIDS today—an attitude that acknowledges that the virus is a problem and ensures to the greatest extent possible that citizens have the proper knowledge, while also playing down the issue and attempting to show the world how well the problem has been handled.

More recent interventions by the government against HIV/AIDS in Kenya are best exemplified by the Kenya National HIV and AIDS Strategic Plan, which was in effect from 2009 through 2013.¹⁷² This strategic plan, developed by KNACC and NASCOP, is summarized in four

¹⁷⁰ UNAIDS, "AIDS Badge Curriculum."

¹⁷¹ NACC and NASCOP. "Kenya AIDS Epidemic Update 2011."

¹⁷² Ibid.

pillars: health sector HIV services delivery, sectoral mainstreaming of HIV, community-based HIV programs, and governance and strategic information.

The first, health sector HIV services delivery, deals primarily with the provision of care and treatment to HIV+ people and people living with AIDS. These efforts are supported to a large extent by international aid and international organizations like the United Nations, as well as by the estimated 16,000 community-based organizations (CBOs) that work with HIV/AIDS in Kenya.¹⁷³ It is fitting and proper that the first point of Kenya's strategic plan deals directly with those affected by the disease—those who need the help and support of the government the most.

The second, sectoral mainstreaming of HIV, refers to an area in which Kenya has already had great success. "Mainstreaming" HIV has several positive effects on the fight against the virus: first, it helps to eliminate stigma by showing how widespread the disease is; second, it engenders positive, healthy decision making by making the population more aware of the virus and its dangers; and third, it brings more media attention and thus more international aid, more research, and more investment.

The third, community-based HIV programmes, will be discussed at length in a section below, but essentially refers to the government's ongoing support of the many community based organizations working against HIV.¹⁷⁴

The fourth and final pillar, governance and strategic information, refers to the logistical side of the response to HIV/AIDS. This area of response centers around data collection and analysis, including data on transmission, prevalence, sexual practices, risky behavior, gender equality, etc. Though less involved directly with the care and treatment of those afflicted with HIV/AIDS, this pillar remains of fundamental importance to the fight against HIV/AIDS in Kenya,

¹⁷³ Ibid.

¹⁷⁴ Ibid.

because it not only quantifies the exact extent and effects of the virus, it also quantifies how successful the various responses to HIV/AIDS are.

The strategic plan for responding to HIV/AIDS is, technically, just words on a page. In truth, the Kenyan government does struggle to implement legislation and strategic initiatives, in large part due to lack of resources and instability. At the same time, though, the strategic plan is impressive. It demonstrates an understanding of HIV/AIDS beyond the biological and it relies justifiably on the help and support of international donors and NGOs, yet it still addresses the most pressing problem of HIV/AIDS—the millions of infected Kenyans.

Kenya's response to HIV/AIDS has clearly not been perfect, and even today the government occasionally attempts to play down the epidemic to encourage international investment and tourism.¹⁷⁵ Yet at the same time, the government has mounted significant resistance to the HIV/AIDS crisis, and significant support for organizations who hope to do the same.

Community Based Organizations

As mentioned above, it is estimated that 16,000 CBOs in Kenya deal with HIV/AIDS.¹⁷⁶ This section will not detail all of their work, but will instead reflect on the benefits of community based care using one organization as a particular example.

Mirror of Hope is a community-based organization (CBO) that was founded in 2010 at Our Lady of Guadalupe Catholic Church, just outside Kibera.¹⁷⁷ According to the interim director of Mirror of Hope, Judy Onyango, the organization has two programs through which it directly responds to HIV/AIDS and its associated problems. The first focuses on vulnerable and orphaned

¹⁷⁵ Ibid.

¹⁷⁶ Ibid.

¹⁷⁷ Judy Onyango, interviewed July 15, 2013.

children, and the second focuses on empowering HIV+ women, particularly those who are single and pregnant. Both programs are concentrated only on four villages of the Kibera slum, making the focus of the organization very community-based.

In order to help protect vulnerable children, Mirror of Hope sponsors supervised after-school programs on weekdays, day-long programs on weekends, and week-long “camps” during school breaks. During these programs, Mirror of Hope workers and volunteers not only entertain and play with the children, but also engage with them in discussion about many of the topics addressed through the AHAPPY curriculum: how to live justly, how to make good decisions, how to rise above peer pressure, and many other life skills that relate to HIV/AIDS.¹⁷⁸ Thus, the program has a dual purpose: first, keeping children busy and safe when they are not in school; and second, educating them on ways to avoid becoming infected by HIV. In many cases, the organization is also able to pay for students to go to secondary school when they could not otherwise afford it.¹⁷⁹

In its other program, Mirror of Hope provides a support group for HIV+ women that meets weekly for them to gather and discuss problems they are facing and ways to address them. In addition to the support group, Mirror of Hope trains women to open their own small businesses, producing small and useful items like soap, jewelry, baskets, or bags. The organization provides women with small start-up loans of money and materials, which allows them to purchase the requisite goods and begin making products. If the small businesses become successful, the

¹⁷⁸ The AHAPPY curriculum has not been introduced to Mirror of Hope programs yet. AJAN already provides significant funding and logistical support to Mirror of Hope, so AHAPPY curriculum is planned to be introduced in the near future.

¹⁷⁹ Onyango, July 15, 2013.

organization also acts as a bank for the women, protecting the little money they make from parents, husbands, siblings, children, or strangers who otherwise might take it.¹⁸⁰

According to Onyango, the goal of Mirror of Hope is to “engage the women to do something, to give them that hope that they may have lost along the way.”¹⁸¹ It seeks to bring women out of denial about their HIV status, to acceptance of their situation and the realization that they are not alone. By providing financial loans and the security and support of a group of other HIV+ women, Mirror of Hope provides women with exactly that which the name promises: hope.

Mirror of Hope is only one of thousands of community-based organizations in Kenya that have made significant strides in responding to HIV/AIDS. As effective as nationwide education and response programs can be, there are ways in which community-based responses to HIV/AIDS have significant benefits.

The first is due to the immense value of one-on-one treatment and care. What community-based organizations lack in reach and resources, they make up for in personal investment and compassion. Though it is easy to be cynical about community-based organizations from a broad perspective (after all, Mirror of Hope only works with around 150 to 200 people—how much difference does that really make, anyway?) it is much more difficult to be cynical after seeing the difference such organizations make in the lives of those lucky enough to receive their services. Any response to HIV/AIDS would be inadequate without the individual care and concern that community-based organizations provide.

One significant benefit of CBOs like Mirror in Hope is that—unlike organizations like the United Nations—they are invested directly in the communities that they serve. This provides several additional advantages: first, CBOs often hire and employ people from their community,

¹⁸⁰ Ibid.

¹⁸¹ Ibid.

which improves employment opportunities and promotes awareness in the area; second, CBOs are aware of the specific challenges being faced by the members of their community, since they live and work in the same area; third, CBOs are often seen as more personal in comparison to international or nationwide organizations, which can often appear intimidating, a fact that encourages more people to make use of their services; and fourth, CBOs are often able to do more with less—using less funding to make a significant impact in the lives of those whom they serve.

In addition to the various social media advertising strategies and formal education programs above, CBOs provide an invaluable way of mainstreaming HIV/AIDS and getting relevant information to the public. Walking through Kibera today, one sees dozens of clinics and social programs that refer directly to HIV as a problem. This visibility alone brings about a social conscience that allows the population as a whole to realize that HIV/AIDS is a problem, and encourages them to mitigate its effects and limit its transmission.

It would be naïve to think that a problem as wide-ranging and complex as HIV/AIDS could be solved solely by the work of CBOs. But it would be just as naïve to assume that because they do not provide long-term solutions, CBOs are unnecessary. There are more dimensions to the fight against HIV/AIDS than simply getting rid of the virus. There is also the need to support those who already have been infected—to, in the words of Paul Farmer, accompany them along the way.¹⁸²

The Roman Catholic Church

Any discussion of responses to HIV/AIDS in Kenya—or, indeed, in all of sub-Saharan Africa—that failed to mention the Catholic Church would be woefully inadequate. Orobator, along with many other theologians and scholars, has called the Catholic Church's response to HIV/AIDS

¹⁸² Paul Farmer and Gustavo Gutierrez, *In the Company of the Poor* (New York: Orbis Books, 2013), 11.

in Africa “second to none,” citing specifically the involvement of clergy and lay Catholics alike in pastoral care of those infected by HIV throughout Africa.¹⁸³

Orobator divides the church’s response to HIV/AIDS in Africa into two levels—the hierarchy, and the communities. By hierarchy, he refers to the Catholic Church as an institution, including the papacy and papal offices, the bishops, and the Congregation for the Doctrine of the Faith. This part of the church, he says, is well-deserving of some of the criticism it has received, particularly in the area of HIV/AIDS prevention.

As mentioned above, the church has received considerable pushback since the rise of the epidemic for its teaching in *Humanae Vitae*, which prohibits the use of artificial contraception. It has long been argued that this encyclical, issued in 1968 by Pope Paul VI, has negatively affected the availability and use of condoms in countries affected by HIV.¹⁸⁴ To some extent, this should be obvious. As Austen Ivereigh notes in *America*, many were of the belief that “the church was effectively telling someone who was at the risk of transmitting or being infected by AIDS that they should never use a condom, because a condom was inherently contraceptive and therefore evil.”¹⁸⁵ It is likely that this has been an effect of *Humanae Vitae*, whether intended or unintended.

Yet critics of the church on *Humanae Vitae* are giving a black and white version of what is really a color image. The church teaching on the use of condoms, for example, is more complex and fluid than it might initially seem. In November of 2010, Pope Benedict XVI made statements to a German journalist that seemed to indicate a shift in the Vatican’s policy on condoms. When asked if condoms could ever be morally justified, Benedict XVI responded, “There can be single justified cases, for example when a prostitute uses a condom, and this can be the first step toward

¹⁸³ Agbonkhianmeghe E. Orobator, interviewed July 12, 2013.

¹⁸⁴ Austen Ivereigh, “Pope on Condoms and AIDS: The Background,” *America*, November 21, 2010.

¹⁸⁵ *Ibid.*

a moralization, a first act of responsibility in developing anew an awareness of the fact that not everything is permissible and that we cannot do everything we want.”¹⁸⁶ He was quick to temper his statements, saying, “[The Church] of course does not regard it as a real or moral solution, but, in this or that case, there can be nonetheless, in the intention of reducing the risk of infection, a first step in a movement toward a different way, a more human way, of living sexuality.”¹⁸⁷

Moral theologians have in fact argued for more than a decade that church teaching on contraception does not preclude the use of a condom in all circumstances. Two Jesuits, Rev. James Keenan, SJ, a moral theologian, and Rev. Jon Fuller, SJ, a physician, argued in 2001 that “Catholic moral theologians ... have been nearly unanimous in arguing not only that the Catholic tradition is not *per se* opposed to [the use of condoms] for disease prevention, but that Roman Catholic principles actually help to convey the moral liceity of their use.”¹⁸⁸ In their paper, the two go on to argue that the use of condoms in the case of a heterosexual married couple, where one partner is infected by HIV and one partner is not, is a morally justified circumstance to use condoms. The two show that the *intention* in this particular case is not that the condom prevent reproduction, but that it prevent infection. Contraception is a side-effect that is neither intended nor the means to the right effect (in this case, preventing infection). Using the principle of double effect, Keenan and Fuller effectively argue for a case in which the use of condoms is morally justified by church teaching.¹⁸⁹

Keenan and Fuller do not stop at the case of a married couple where one partner is infected with HIV, however. They also go on, in the same paper, to discuss the morality of condom use in

¹⁸⁶ Peter Seewald, “Light of the World: The Pope, the Church, and the Signs of the Times,” Ignatius Press, 2010; Mitchell Landsberg, “Pope Says Condom Use OK In Some Cases,” *The Los Angeles Times*, November 21, 2010.

¹⁸⁷ Ibid.

¹⁸⁸ James F. Keenan and Jon D. Fuller, “Condoms, Catholics, and HIV/AIDS Prevention,” *The Furrow* 52 no. 9 (2001): 459-67.

¹⁸⁹ Ibid.

an unmarried couple, yet again showing that the church's teaching on condoms is not black and white. They argue that, although sexual relations outside marriage are deemed morally wrong because they violate the principle of chastity, the principle of lesser evil can be used—without mitigating the immorality of the violation of chastity—to justify the use of a condom in preventing transmission of a deadly disease. In this case, the two argue that justice (i.e. not causing the death of one's partner) trumps church teaching on the use of contraception.¹⁹⁰

Keenan and Fuller are in no way alone in their opinion on the use of condoms in a time of HIV/AIDS. Referring directly to condoms and their ability to prevent infection and save lives, Orobator writes, “Against the backdrop of longstanding principles of Catholic sexual ethics... another position has emerged that maintains the moral priority and imperative of protecting life within the context of sexual intercourse, whether conjugal or transactional.”¹⁹¹ In addition, Archbishop Kevin Dowling of South Africa was quoted as saying that those infected with HIV/AIDS “should use a condom in order to prevent the transmission of potential death to another.”¹⁹² The growing trend among Catholic theologians and leaders is a general, albeit wary, support for the use of condoms in cases where they prevent the spread of HIV/AIDS.

Although this trend is encouraging, church teaching remains church teaching, and the perception of the public, however incorrect or misled it may be, has real effects on the prevention of HIV/AIDS. In *Applied Ethics in a World Church*, Hogan points to the confusion church teaching can cause on condoms, writing, “On Sundays the priest tells him: ‘Don’t use condoms!’ Then during the week the government run health care center tells him: ‘Use condoms!’ People are

¹⁹⁰ Ibid.

¹⁹¹ Agbonkhiangmeghe E. Orobator in *Applied Ethics in a World Church* (New York: Orbis Books, 2008), Linda Hogan, ed., 148.

¹⁹² Landsberg, Mitchell.

confused.”¹⁹³ It is clear that, although the theological details of the church teaching on condoms are less rigid than the public might think, the hierarchy of the Catholic Church has probably had some negative effects on the prevention of HIV/AIDS in Kenya, a nation that is about a quarter Catholic.

Whereas the church’s response to HIV/AIDS in the area of prevention has been mixed, in the area of treatment, the Catholic Church has seen vast success. In total, the Catholic Church provides roughly 26 percent of all HIV/AIDS care and education in the world, and has lobbied consistently for increased spending on AIDS care and treatment.¹⁹⁴ In *Breaking the Conspiracy of Silence: Christian Churches and the Global AIDS Crisis*, Donald Messer, who is not a Catholic, points out that “the Roman Catholic Church probably offers more hospices, hospitals, orphanages, and parish programs providing care for people with AIDS and their families than any other religious organization.”¹⁹⁵ In addition to the one quarter of global AIDS care and education that the Church provides, hundreds of NGOs operate in the name of and spirit of the Catholic Church.¹⁹⁶

Most importantly to note, however, is that there is much more to the Catholic Church than its hierarchy. The movement of grass-roots Catholics in sub-Saharan Africa in response to HIV/AIDS over the past three decades has been enormous. As Orobator points out, “That’s the church too!”¹⁹⁷

Too often, the public associates only the negatives of the hierarchy with the Catholic Church while forgetting about the huge amount of good that grass-roots movements of Catholics accomplish on a day-to-day basis. While the upper levels of the church battle over issues of

¹⁹³ Hogan, 159.

¹⁹⁴ Donald E. Messer, *Breaking the Conspiracy of Silence: Christian Churches and the Global AIDS Crisis* (Minneapolis: Fortress Press, 2004), 102; Hogan, 158.

¹⁹⁵ Messer, 102.

¹⁹⁶ Ibid.

¹⁹⁷ Orobator, July 12, 2013.

prevention and contraception, these lower levels of the church—the people who run the schools, care for the sick, and help those in need—continually provide for victims of HIV/AIDS in a way that few other organizations in the world can claim. While much of this care is medical, it is also often pastoral. Drawing on the ideas of liberation theology, popularized in the second half of the 20th century by men like Gustavo Gutierrez and first published in his work, *A Theology of Liberation*, Catholics the world around have worked for several decades to eliminate structures of evil and violence that continually oppress the poorest and sickest on Earth.¹⁹⁸

In many cases, this disconnect between the hierarchy of the church and those who do its work around the world has led to frustration for those interacting with the problems on a daily basis. This frustration, in turn, led to direct conflicts between what would save lives, and what the church would want. In Orobator's words, "Sometimes that meant just doing what was necessary."¹⁹⁹ He provided an example of a case like this, in which nuns working in rural Kenya to prevent HIV/AIDS would speak frankly with their patients, telling them the benefits of condoms and exactly where they could go to obtain them. Knowing that a patient will be sexually active and knowing how prevalent HIV is in a particular area quickly changes one's attitude towards church teaching.

It is clear that the church—because of its teaching and historical attitudes towards sexuality and contraception—has been the subject of much controversy when it comes to the fight against HIV/AIDS around the world. Yet it is just as clear that nearly no other worldwide organization has worked as hard as the Roman Catholic Church and its followers to respond to the debilitating effects of the HIV/AIDS epidemic, both in terms of treatment and care, and in terms of prevention.

¹⁹⁸ Gustavo Gutierrez, *A Theology of Liberation: History, Politics, and Salvation* (New York: Orbis, 1973).

¹⁹⁹ Orobator, July 12, 2013.

Kenya's Response to HIV/AIDS

As the section we have just completed shows, more goes into the fight against HIV/AIDS than just international aid and lip service from non-governmental organizations. Every day in Kenya, hundreds, if not thousands, of people wake up knowing that the entirety of their day will be dedicated to responding to HIV/AIDS, either directly or indirectly: providing treatment for those who are infected, caring for those who are dying, teaching those who are orphaned, educating those who know too little, or planning and strategizing for a future free of HIV/AIDS. This response is multifaceted, layered, and complex. In Kenya it involves 16,000 community-based organizations, the government, the Catholic Church, the United Nations, and too many other institutions and organizations to list.

We have traced the history of HIV/AIDS, and through it, we have come to the problems that Kenya faces and the way in which the nation responds to them. But there are dozens of problems we have barely addressed at all. These are the many deeply rooted ethical problems HIV/AIDS both engenders and exacerbates. From here forward, we turn our attention toward these issues, the ways in which they have been addressed, and strategies for eventually eliminating them once and for all.

Part Two: Ethical Issues of HIV/AIDS in Kenya

CHAPTER FOUR

Gender Inequality

The following section of this paper addresses five ethical issues that are fundamentally connected to HIV/AIDS, and which directly and regularly affect Kenyans, whether they are HIV+ or not. In each case, the stage will be set by analyzing contributing factors to the current issues, including cultural and religious norms, any relevant legislation or acts on behalf of the government, and in many cases, recent statistics. Each of these issues are complex and multifaceted, and none of them have easy solutions. The first step to approaching a solution, however, is understanding the problem. This section seeks first to explain these problems in a straightforward fashion, and then posit potential solutions.

Gender Inequality in Kenya

Today, Kenya continues to struggle with gender inequality, in large part due to traditional practices which, though no longer widely observed, continue to exert significant power over the nation's social structures. As a result, HIV/AIDS disproportionately affects women by a significant factor. First, we will begin with a few examples of the lower role and status of women in Kenyan society, followed by an analysis of how HIV/AIDS transmission affects and is affected by this inequality.

In 2010, Kenya's new constitution was hailed as a great success for providing, for the first time, truly equal rights to women. The constitution contains several explicit references to problems that the nation has faced with gender inequality—including an entire chapter that describes and defines crimes against women and girls—and is highly optimistic for the role of women in the future.²⁰⁰ What this means, however, is that pre-2010, women were not even recognized as the equals of men nominally. Even after the ratification of the constitution, much of the country—particularly the rural areas—remain unaware of its contents. Life has, for the most part, continued on in the same way it has for the previous decades, with women retaining a universally lower status than men.

For the vast majority of its history and even in some areas today, Kenya's male leaders and citizens have systematically discriminated against women. This discrimination comes in the form of sociological practices that are, in general, not secretive or nuanced. Rather, they are direct and intentional inhibitors of the rights of women. For example, it is extremely rare in traditional Kenyan society (almost to the point of being nonexistent), for a woman to inherit land from her

²⁰⁰ Jacob Kushner, "Kenya: A Slap Caught on Tape Sparks Debate Over Violence Against Women," *Global Post*, October 10, 2013.

father or from her husband if she is widowed.²⁰¹ Young Kenyan women are often taken out of school at a young age and married off, “their bride price sometimes paying for their brothers’ school fees.”²⁰²

The statistics form a long, depressing list. Women perform 49 percent of the agricultural work in Kenya, but own less than five percent of the land upon which that work is performed.²⁰³ According to a study performed by USAID in 2008, 45 percent of Kenyan women reported that they had experienced sexual violence, one third of that group indicating that the perpetrator had been a partner or family member.²⁰⁴ Even more disturbingly, “twelve percent indicated that their first sexual intercourse occurred against their will.”²⁰⁵

A particularly illustrative example of how the status quo on women has been maintained came in the fall of 2013, just two weeks before the infamous shooting at the Westgate Mall in Nairobi. While being filmed by a news crew, Nairobi Governor Evans Kidero violently slapped parliamentarian Rachel Shebesh directly on the face in the midst of a crowd of men and women. While the slap was disturbing, the response on the part of Kenyan society was perhaps even more so. In the wake of the incident, many people—both men and women—argued that the assault was warranted and appropriate, and that Shebesh was being too confrontational with a man whom she should have shown greater respect.²⁰⁶

At an event organized by outraged women after the assault, attitudes were just as disturbing. When the Kidero incident was mentioned, many men in the audience chuckled, and Pentecostal Bishop Stephen Ndicho opened his address by saying, “The bible says women are a

²⁰¹ Deborah Espinosa, “Kenya: New Constitution Promises Unprecedented Rights for Women,” *Global Post*, March 13, 2012.

²⁰² Ibid.

²⁰³ Ibid.

²⁰⁴ Kushner, “Slap Caught on Tape.”

²⁰⁵ Ibid.

²⁰⁶ Ibid.

weaker sex. Even though women are a weaker sex, men are called on to protect women.”²⁰⁷ The women who organized the event, on the other hand, provided horrifying stories of rape, abusive sexual relationships, 60-year-old men marrying 12-year-old girls, and the humiliating and permanently damaging traditional practice of female circumcision.

Perhaps the most debilitating aspect of gender inequality in Kenya comes in the area of education. On average, women in Kenya have far fewer educational opportunities than men, and those that are in school are often under a variety of pressures that allow them less time to focus on their studies. This results in lower literacy rates for women, lower numbers of women in colleges and universities, and lower proportions of women in successful, satisfying, high-paying careers. As an example, only 8.1 percent of Kenya’s parliamentarians are female. In nearby Tanzania and Rwanda, the percentages are 28 and 48, respectively.²⁰⁸

Beatrice Maina, the principal of St. Aloysius Gonzaga, sees this problem even among her own secondary school students. During the school day, the female and male students are provided with the same materials, and taught in similar classes by the same teachers. They are provided the same opportunities for exercise, practice, and learning. Yet test scores of graduating students from St. Aloysius on the KCSE show vast inequalities between male and female performance, with females performing, on average, nearly a full letter grade below males. This difference on an exam as important as the KCSE means that a much lower proportion of St. Al’s female graduates attend college as compared to their male counterparts.

Maina attributes this disconnect, in large part, to the pressures under which the young female students at St. Aloysius are constantly working. In addition to the long, nearly 12-hour days

²⁰⁷ Ibid..

²⁰⁸ Atsango Chesoni, et al., “Promoting Women’s Human Right and Enhancing Gender Equality in Kenya,” Swedish International Development Cooperation Agency, July 2006, 6.

at school, Maina says that many female students also return home to the slum and are expected to clean, cook, or work at their family's business. Those whose mothers have died, often as a result of HIV/AIDS, also serve as the primary caregivers for their younger siblings. Maina admitted that many of her female students were likely in abusive relationships, sexual and otherwise. These relationships, mostly with older men, take away valuable time and energy that could otherwise be put toward studies while causing psychological damage that lasts for many years.²⁰⁹ While some of the young men at St. Al's are also under these (and other) pressures, both Maina and several of the school's teachers argue that they are expected to do far less at home, precisely because they are expected to do so well in school so that they might attend college.

Gender Inequality and HIV/AIDS

Among African countries, Kenya is not alone in failing to advocate sufficiently for gender equality. The issues of women's rights and gender equality are both ethical and global, as relevant in the United States as they are in Kenya, though certainly not as dire. The focus of this paper is not, however, on resolving the worldwide injustice of gender discrimination. Rather, it is specifically on the issue of HIV/AIDS. How, then, does HIV/AIDS relate to the gender discrimination just described?

²⁰⁹ One day at St. Aloysius, I was speaking with a school administrator about the problems facing the school's students. She told me that perhaps the single greatest problem affecting St. Aloysius female students was the pressure at home for them to get married (or at least develop relationships) in order to achieve financial stability. Many of the children are adopted because both of their parents have died. In those cases, the students are somewhat of a financial burden on their adopted family, which is often—but not always—the family of their aunt or uncle. Thus, especially for young women, marriage (particularly to an older man) is seen as a solution to this problem. Consider an example. The administrator told me the story of one student at St. Aloysius who was born and raised in the northern, rural part of the country. At the age of 12, she was married off and was in a sexual relationship with a man more than 20 years her senior. Eventually, her surviving family paid for her to travel to Nairobi, where she lived with her aunt so that she could attend secondary school, which was not an option in her rural hometown. She had to sneak away at night to be able to leave her rural town without her “husband” knowing, and she had not seen him since.

A few facts and statistics are necessary to establish the reality that women are disproportionately affected by HIV/AIDS, particularly in sub-Saharan Africa. Women comprise 60 percent of people living with HIV/AIDS in sub-Saharan Africa, as opposed to 50 percent globally.²¹⁰ In general, the proportion of women living with HIV/AIDS has increased over the past ten years, and women are more than twice as likely to contract HIV/AIDS from heterosexual intercourse with an infected partner as opposed to the reverse.²¹¹ This higher rate is primarily a result of biological factors—the vagina provides a larger surface area and more vulnerable tissues than that of male genitalia, and is also more vulnerable to tears and other wounds during intercourse, which can increase transmissibility. HIV/AIDS is the leading global cause of death for women in their reproductive years (15-49), and among young people, the HIV prevalence rate for women is twice that of men.²¹²

The difference in rates are not the result of exclusively biological factors, however. In large part, they are sociological—many of the factors listed above in discussing the status of women are directly related to HIV/AIDS. Female genital mutilation, for example, not only increases the risk of HIV transmissibility during vaginal intercourse, it often also encourages anal intercourse (essentially by making vaginal intercourse difficult, if not impossible), which has been shown to be a much more risky sexual behavior, particularly for the receiving female.²¹³ In Kenya, female genital mutilation is a traditional practice that still exists in isolated populations, particularly in

²¹⁰ World Health Organization, “Gender Inequalities and HIV/AIDS,” 2014, accessed March 13, 2014. http://www.who.int/gender/hiv_aids/en/.

²¹¹ Estimates here range widely. Some sources say that women are ten times more likely to contract HIV/AIDS from heterosexual sex with an infected partner than the reverse. Recent studies, however, have shown the rate to be closer to two to three times more likely per sex act, though circumstances vary. See: AMFAR, “Statistics: Women and HIV/AIDS,” 2014, accessed March 13, 2014; G. Corey, *The Invisible Epidemic* (New York: Harper Collins, 1992), 356.

²¹² AMFAR, “Statistics: Women and HIV/AIDS.” <http://www.amfar.org/about-hiv-and-aids/facts-and-stats/statistics--women-and-hiv-aids/>.

²¹³ McLean, S, *Female Circumcision, Excision, and Infibulation*; Public Health Agency of Canada, “HIV Transmission Risk: A Summary of Evidence.”

rural areas, and thus continues to be one of the many contributing factors to the disproportionate effect of HIV/AIDS on women.

The practice of marrying off young girls further increases their risk of contracting HIV. Many of these young women are forced to enter into sexual relationships long before their bodies are sufficiently developed. This leads not only to the horrific psychological side effects of abusive and forced sexual relationships, but also biological dangers of damage to the genitalia and thus, an increased risk of HIV/AIDS infection.²¹⁴

Wife inheritance is another practice that severely exposes women in Kenya to HIV/AIDS by encouraging polygamous relationships between a single man and multiple women. A married man who inherits his brother's wife now has two; if that man is HIV+, he is now not only endangering his wife, but his brother's, as well.

These factors, however, are just specific examples of practices that increase the already high biological risk of women contracting HIV/AIDS. Perhaps the greater issue is the overall low status of women at the societal level. When women are sold off to the highest bidder, forced into sexual relationships at a young age, or denied the right to property, broader problems arise. As a result of these many factors, women are not empowered in Kenya, by almost any definition of that word. They are less able to make choices about their relationships, less able to make decisions about when and how they have sex, if at all, and they are less likely to be able to live a safe and stable life without relying on a more powerful man.

These facts connect directly to higher rates of HIV/AIDS. As an example, imagine a case where a young Kenyan woman is being forced to have sex with an older man who she knows is HIV+. She has almost no ability to stop the act from taking place—she faces the threat of physical

²¹⁴ McLean, S.

violence from the man if she refuses, and she may also rely on the man for financial support, food, shelter, or other protection. Even if she tries to refuse, he may rape her. There is a far smaller chance of this Kenyan man being caught for such a crime than, for example, an American man committing the same crime, for at least two reasons: first, the resources of police in Kenya are severely limited relative to the crime rate; second, the crime of rape is more “socially acceptable” in Kenya than in the U.S. So, the young woman essentially has to submit to having sex with the man.

Assuming the young woman has had sufficient education (though it is possible, particularly in rural parts of the country, that she has not), obviously if she knows that the man is HIV+, she is probably aware that they should use a condom. But she has little chance of having access to a condom or the finances to buy one, and even if she is able to obtain one, it remains up to the man, in the position of power, to decide whether or not to use it. Condoms in the traditional African context are often seen as unmanly, limiting fertility and eliminating risk.²¹⁵ So, even if a condom is available, the man might choose not to wear it.

Again, if the woman has been sufficiently educated, she would know that engaging in anal intercourse is more dangerous than vaginal intercourse. Just like she had no choice in having sex, however, she similarly has no power to make decisions about the specifics of the act. The man, again, is the one who decides. Add in the fact that the young woman might have been the victim of genital mutilation, or might be prepubescent, and more risk factors for HIV/AIDS transmission arise. Now, imagine that this man has numerous sexual partners in similar relationships, and it becomes even clearer why women are more likely to be HIV+ than men.

²¹⁵ Messer, *Breaking the Conspiracy of Silence*.

It is important to qualify this hypothetical situation, however. While such a relationship is indicative of some relationships in Kenya and serves as a valuable thought experiment in understanding the many risk factors that put Kenyan women in danger, there are many relationships that are nothing like the one described above. Many Kenyan couples marry and live monogamous and healthy lives, and produce healthy children who go on to do the same. Many young Kenyan women—like those at St. Aloysius—are able to obtain an education that concurrently gives them knowledge of risky behaviors and empowers them to make good decisions about their sexuality. Assuming that all situations—in this case, all sexual relationships—are as bad as the worst imaginable case is one of the most common mistakes when considering the developing world and sub-Saharan Africa.

Solving the Problem

Kenya's new constitution is undoubtedly a step in the right direction toward a nation free from gender discrimination and injustice. As a society, Kenya is slowly moving towards accepting greater roles for women and rewarding them more fairly for their talents and contributions. Just like in the U.S., these changes are coming slowly and gradually, validated and extended from time to time by particularly outspoken or successful women concerned with the state of affairs during their time.

Yet there remains work to be done, and realistically, these changes are coming too slowly for the world to wait around until the status of women improves. Changes to the constitution are not going to determine the future of Kenya's women singlehandedly. There are many steps that can and should be taken in the near future in order to limit the effect of HIV/AIDS on women that do not rely on the overarching cooperation of Kenyan society as a whole.

Mirror of Hope, the community based organization mentioned previously, is a great example of the types of interventions that can and do support and empower Kenyan women. More organizations like these—and greater funding for those that already exist—would go a long way in improving the status of Kenyan women. Mirror of Hope and similar organizations work because they provide positive reinforcement for women who are the victims of sexual violence by creating a support system that is independent of sexual relationships. Many sexual relationships, particularly among Kenya's poorest and most vulnerable women, become forced because these women cannot afford to turn down financial security promised to them by a man who demands sex in return. When they are able to receive support from an organization like Mirror of Hope—in the form of food, monetary loans, business advice and consulting, skills training, literacy education, medical treatment, or psychological counseling—they are less likely to have to rely on an abusive sexual relationship to procure any of these. They emerge more independent, better able to make money and survive on their own, and less likely to feel that selling their body is the only way they can ensure their health and survival.

On a societal level, more focus should be put on social advertising that establishes women's equality as an issue that demands attention. Because it has not been addressed, many Kenyans frankly struggle to see that the status quo is unjust—women have always been of a lower status, and it will be that way for a long time. But without pointing out on a societal level the injustice in sexual relationships where men dominate all decision-making, change will be difficult to encourage. Without pointing out that it is wrong for a 60-year-old to marry a 12-year-old at her father's request, or that it is wrong to require sex in exchange for money or protection, change will be difficult to encourage.

Many Kenyans know that gender inequality is an ethical issue—the group of outraged citizens who spoke up after Nairobi’s governor slapped a woman on public television is evidence of that. The goal, then, is getting the majority of the population to realize the same as quickly as possible. Until then, encouraging the growth and widespread implantation of support systems that empower and care for women is an effective strategy that can begin to reverse the trends that have led to the infection of so many women.

CHAPTER FIVE

Sexuality

Homosexuality has long been connected with HIV/AIDS, in large part because so many of its earliest and most public cases involved gay men. Moving forward from those early cases—away from GRID and toward HIV/AIDS—the virus has remained an illness that is at least indirectly associated with the GLBTQ community. Global, gay superstars like Freddie Mercury have become intrinsically representative of the affliction with which they struggled, and straight celebrities like Magic Johnson have been the subject of endless speculation on their sexual identity simply for being HIV+. This connection is not entirely without a factual basis. As an example, in the United States, men who have sex with men compose more than half of all people living with

HIV, despite representing only four percent of the entire population.²¹⁶ Statistics like these are universally common and unarguably convincing: men who have sex with men are at a higher risk for contracting HIV/AIDS, as a result of both biological and sociological factors. This section will first address the Kenyan attitude towards homosexuality and men who have sex with men, using recent sociological data. Then, it will analyze how this attitude towards homosexuality affects HIV/AIDS prevention and treatment in a Kenyan context. Many ethical issues arise when discussing homosexuality and HIV/AIDS, including stigma, discrimination, and violence. Each of these is relevant in Kenya, and each must be addressed as the world moves forward with HIV/AIDS prevention and treatment.

Homosexuality in Kenya

The attitude of Kenyan society towards homosexuality shares little in common with the global trend—particularly among developed, European nations—of increasing acceptance of GLBTQ persons. In fact, polling on public perception of homosexuality indicates that Kenya remains one of the most unfriendly nations in the world, at both societal and political levels, toward those who identify as GLBTQ.

²¹⁶ “Men who have sex with men” (“gay, bisexual and other men who have sex with men” is rarely used, sometimes abbreviated MSM) is a phrase used frequently when discussing HIV/AIDS and most often refers specifically to anal intercourse. It is used instead of “gay” or “bisexual” in order to be inclusive of any and all men who engage in sexual intercourse, regardless of their sexual identity. This puts more of an emphasis on the actual sexual act and the HIV transmission risk that comes along with it—which, among men who have sex with men, is significantly higher—rather than on the sexual identity of the person engaging in the act. The terms are not exactly interchangeable, and both will be used in this paper: when discussing HIV/AIDS transmission and transmissibility, it is more common to use “men who have sex with men”; when discussing stigma and the attitudes of society, it is more common to use “homosexual” or “GLBTQ” as these terms are both more inclusive of the larger community that continues to struggle with discrimination. See: Centers for Disease Control and Prevention, “HIV Among Gay, Bisexual, and Other Men Who Have Sex With Men,” *Division of HIV/AIDS Prevention*, September 26, 2013, accessed March 17, 2014; U.S. Department of Health and Human Services, “U.S. Statistics,” *AIDS.gov*, May 6, 2012, accessed March 17, 2014, <http://aids.gov/hiv-aids-basics/hiv-aids-101/statistics/>.

According to a Pew Research Center poll conducted in 2007, 96 percent of Kenyan citizens believe that “homosexuality is a way of life that society should not accept,” the fifth highest rate among 45 countries polled.²¹⁷ At a societal level, homosexuality remains widely and openly unaccepted by Kenyans. In February of 2012, a meeting organized by and for GLBTQ advocates and activists was interrupted by a mob of more than 100 young people, according to *Daily Nation*, Kenya’s flagship news source. The mob, though composed mostly of young people, was led by “religious leaders and village elders,” and a Muslim religious leader, Sheikh Amir Zani, called the meeting of GLBTQ activists “illegal, ungodly, and unacceptable,” threatening to incite violence against gays if such actions continued.²¹⁸

A year previously, in 2011, prominent Muslim clerics in Kenya called publicly for harsher laws and punishments against practicing homosexuals in accordance with Sharia law. These punishments would include the death penalty or life sentences for men and women caught in homosexual relationships. According to *Daily Nation*, Sheikh Mohammed Khalifa said in reference to homosexuals: “We are asking Kenyans to shun businesses owned by such people and further show them open discrimination as a way of stopping the beastly act. They grossly abuse rights of others and should not be accepted among the society.”²¹⁹

By no means is homophobia in Kenya limited to Muslim religious leaders, however. It is politically sponsored, as well. Former Prime Minister Raila Odinga has made openly homophobic comments to the Kenyan public, including calling homosexual acts “unnatural” and calling on Kenyans to out homosexuals and ensure that they are arrested. Bewilderingly, he cited the fact that there are more Kenyan women than men as a reason that men should not practice homosexuality:

²¹⁷ Pew Research Center, “Pew Global Attitudes Project,” October 4, 2007, 35, 117.

²¹⁸ Daniel Nyassy, “Gays Flee Asirate Residents Storm Likoni Seminar,” *Daily Nation*, February 23, 2012.

²¹⁹ Galgalo Bocha, “Clerics Seek Harsher Laws for Gays,” *Daily Nation*, June 13, 2011.

“It is madness for a man to fall in love with another man while there were plenty of women.”²²⁰ In Kenyan prisons, surveillance cameras have been installed in order to discourage and prevent homosexual behavior between male inmates, while efforts to provide condoms to inmates to prevent the spread of HIV/AIDS have been repeatedly denied.²²¹ This homophobia is not a new trend. In 1999, then-Kenyan President Daniel arap Moi called homosexuality a scourge that went against Christian principles.²²²

Beyond the opinions of the public and of political leaders, there remain significant legal barriers against homosexuality that continue to discriminate against GLBTQ persons legally while encouraging stigma against them socially. The Kenyan Penal Code, Chapter 63, Section 162, refers specifically to homosexual acts, and reads: “Any person who has carnal knowledge of any person against the order of nature; or permits a male person to have carnal knowledge of him or her against the order of nature, is guilty of a felony and is liable to imprisonment for fourteen years.”²²³ In Section 165, the code reads:

Any male person who, whether in public or private, commits any act of gross indecency with another male person, or procures another male person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person with himself or with another male person, whether in public or private, is guilty of a felony and is liable to imprisonment for five years.²²⁴

It is clear that these laws are difficult to enforce, but they provide an official basis at the societal level for harassment and violence against those who identify as GLBTQ. The non-governmental Kenya Human Right Commission cites the official laws against homosexuality as being the cause of a variety of such offenses, including harassment by police, unconstitutional detainment,

²²⁰ Lucas Barasa, “PM Orders Arrest of Gay Couples,” *Daily Nation*, November 28, 2010.

²²¹ Mathias Ringa, “Surveillance Cameras to Curb Gay Sex in Prisons,” *Daily Nation*, November 3, 2010.

²²² Kenya Human Rights Commission, “The Outlawed Among Us: A Study of the LGBTI Community’s Search for Equality and Non-Discrimination in Kenya,” 2011, 5.

²²³ National Council for Law Reporting, “The Penal Code: Chapter 63,” *Laws of Kenya*, 2009, accessed 17 March 2014, 67, <http://covaw.or.ke/wp-content/uploads/2013/11/8.-The-Penal-Code.pdf>.

²²⁴ *Ibid.*, 99.

illegitimate court charges, extortion, and blackmail. GLBTQ sex workers “are often asked for bribes and sexual favours” by police officers, according to the report. Those who fail to provide these favors “are charged with trumped-up charges and sometimes raped by state security officers.”²²⁵

In collecting the data for their report, the Kenya Human Rights Commission also gathered personal testimony from GLBTQ-identifying people who had been subject to violence or discrimination. One young, gay doctor provided the following account, which is indicative of the types of violence to which GLBTQ Kenyans are often subjected:

I was in my house with my partner when persons claiming to be police officers banged my door demanding entry. As I was trying to open they forced themselves in without identifying themselves and proceeded to search the house without a warrant. They claimed they had been tracking my text messages and knew we were about to commit an act of gross indecency (sodomy). They found gay pornographic magazines and also confiscated [sic] my laptop claiming to take it for further hard drive searches. They then made us strip naked, beat us up and told us to have sex for them to see what we do. We refused and they beat us further. They said they would frog march us naked from my forth [sic] floor apartment, call the media and make an arrest of gay people caught in the act. I am a respected doctor and live in the staff residence. They said that if I paid them 100,000 shs [about USD \$1,200] they would leave us alone. I reluctantly agreed. They allowed me to dress, we drove to the bank in my car which they commandeered where I withdrew the 100,000 shs and paid them. I have since changed phone numbers and changed residence.²²⁶

While this doctor was not legally detained under the penal laws cited above, the existence of said laws nevertheless provided for horrific discrimination. This story does not exist in isolation, either. The report is filled with stories of homosexuals being subjected to discrimination, including involuntary oral and anal sexual intercourse, threats of death, forced marriages to “straighten [them] out,” and firings from various jobs.²²⁷ When a same-sex Kenyan couple was married in

²²⁵ Kenya Human Rights Commission, “The Outlawed Among Us,” 22-3.

²²⁶ Ibid., 21.

²²⁷ Ibid., 24-6.

London, there was significant outcry from the public and harassment against one of the grooms' family.²²⁸

This type of police corruption and discrimination is no secret. Kenya's government has formally acknowledged significant problems in the area of GLBTQ rights. The following laundry list of crimes against GLBTQ persons is reported by the government's own Kenya Human Rights Commission:

LGBIs face physical harassment by members of public who mock and assault them for practicing "unnatural" sexual relations. In cases of assault by mob justice, the police often fail to come to their rescue. Upon arrest, police subject them to unnecessary body and house searches allegedly looking for evidence that could link them to other crimes. They are profiled as drug users, past prison convicts or individuals with track records of crimes. They often face arbitrary arrest, are often detained at the police stations, subjected to torture and unnecessary harassment by the police who extort money from them and are only released after bribing their way out. They also suffer sexual abuse from the arresting officers ... When their identities are discovered, LGBIs cannot seek employment or undertake other forms of business—for example running a kiosk. Sometimes, they have to keep relocating to different residential areas to hide their identity. ... Further they are often evicted from their rental houses by neighbours and condemned for their orientation which is termed evil. In cases where they are not evicted ..., they are not allowed to use common utilities in the residential compounds such as swimming pools.²²⁹

²²⁸ See: Muchiri Karanja, "A Family Scarred by Homophobia," *Daily Nation*, October 22, 2009. During my own time in Kibera, uniformed security guards and police officers (there is little distinction between the two) often wandered the streets, purportedly to maintain order and prevent crime. In reality, many of these security officers are so corrupt that they simply wear the uniform in order to extort money, favors, and goods for "protection" from various shop owners and residents. I was warned upon arriving to Nairobi never to trust a man simply because he is wearing a uniform—something we often take for granted in the United States. While I was witness to several acts of violence during my time in Kenya, none was more shocking than when a young boy—no older than 13—riding a bicycle through a crowded street in the slum, happened to bump into one of these uniformed security officers. The officer, without hesitating, stepped towards the young man on the bicycle and swung a nightstick brutally upwards under his chin. The boy was thrown violently off of his bicycle to the hard ground, bleeding profusely from his mouth and face. The security officer shouted at him in Swahili for a few seconds, kicked him as he lay on the ground, and then walked off through the crowd. When I asked a Kenyan friend who was with me at the time what we should do, he told me it was best to pretend it never happened and keep moving away. In our discussions later, he told me that things like this happen all the time, especially in Kibera—that the uniform and reputation of the security officers and police makes them nearly invincible. If a man can get away with violent assault in the middle of a public street, imagine what he could get away with in secret? With experiences like this, it is far easier to see how dire the doctor's situation as described above was.

²²⁹ Kenya National Commission on Human Rights, "Realising Sexual and Reproductive Health Rights in Kenya: A Myth or Reality? A Report of the Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya," April 2012, accessed March 17, 2014, 92-4.

Though some openly and obviously do, many Kenyans today do not necessarily hate homosexuals or wish violence upon them. The attitudes of many Kenyans toward homosexual behaviors can best be categorized as confusion. The majority of straight Kenyan citizens simply cannot understand why or how homosexuals are attracted to members of their own sex. When Barack Obama publicly announced his support of same-sex marriage in 2012, Kenyans—who are generally proud of one of their most famous descendants—reacted strongly against his decision.²³⁰ Even at St. Aloysius, some teachers remain confused by the notion of homosexuality, and do not engage with or understand the issue on the level of human rights and equality.

Despite these huge problems in the area of GLBTQ rights, progress is slowly being made in Kenya. The new constitution, which was hailed as a great success in the area of human rights, does not expressly include provisions for the human rights of GLBTQ persons—law experts argued that if it did, the constitution would have been rejected by the majority of Kenyans in a referendum.²³¹ It does, however, provide universal statements of human rights, including that “every person has inherent dignity and the right to have that dignity respected and protected,” as well as the right to privacy.²³² GLBTQ activists in Kenya are beginning to use such claims to create larger discussions about intrinsic human dignity in the area of GLBTQ rights.

²³⁰ One conversation that I had with a well-educated Kenyan was particularly surprising. We were discussing Barack Obama and what Kenyans think of him, and he brought up that the one thing people held against Obama was his public support of same-sex marriage, which had been announced about a year before my trip to Kenya. This Kenyan told me that he simply could not understand why Obama would support same-sex marriage if he was not gay, and even went so far as to question Obama’s own sexuality. The issue is still so taboo and poorly understood in Kenyan society that it seems progress is not going to be made in the immediate future.

²³¹ Mathias Ringa, “Law Review Experts Rule Out Rights for Homosexuals,” *Daily Nation*, October 18, 2009.

²³² National Council for Law Reporting, “The Constitution of Kenya,” *Laws of Kenya*, 2010, accessed March 17, 2014, 25, <https://www.kenyaembassy.com/pdfs/The%20Constitution%20of%20Kenya.pdf>.

Homosexual Stigma and HIV/AIDS

The effects of stigma against homosexuality on rates of HIV/AIDS infection among Kenya's GLBTQ population range widely from obvious to subtle. Some of these effects are a direct result of stigma against homosexual behavior—including secrecy and unsafe sexual practices. Others are indirect, and relate more to the generally lower status of GLBTQ persons in Kenya. As a combined result of these effects, HIV prevalence among men who have sex with men in Kenya is reported to be 18.2 percent by UNAIDS, a number nearly three times higher than the current overall prevalence of HIV/AIDS among Kenyans.²³³ This section will emphasize a few ways in which stigma negatively effects the prevention and treatment of HIV/AIDS in Kenya.

The most obvious reason for a higher HIV prevalence rate among men who have sex with men is true in all nations just as much as it is in Kenya: homosexual men are generally more likely to engage in anal intercourse, which, as cited previously, is ten times more likely to result in HIV infection for the receiving partner.²³⁴ This is the direct result of biological factors—the lining of the rectum is much more likely to tear or be otherwise damaged during intercourse, which increases transmissibility for both partners. In addition, the secrecy that often must be associated with homosexual behaviors in Kenya—which results directly from stigma and discrimination—results in lower rates of condom use and a higher average number of sexual partners.²³⁵

It is often said that HIV/AIDS is most prevalent in areas of a particular society where secrets are most closely kept. In some countries, like the United Kingdom—in particular, Scotland—this is among IDUs. In India, this is in brothels, where married men have intercourse with infected sex workers and bring the virus home to their wives. In Kenya, this happens to be

²³³ UNAIDS, "World AIDS Day Report," 2012.

²³⁴ Public Health Agency of Canada, "HIV Transmission Risk."

²³⁵ Kenya National Commission on Human Rights, "Realising Sexual and Reproductive Health Rights in Kenya," 93-4.

among homosexuals. In each of these cases, stigma forces the most at-risk populations in a particular society underground, where their behavior is forced to be even riskier. In a situation in which one is avoiding detection by neighbors, friends, family, etc., one is far less likely to ensure that one's sexual practices are safe. Part of responding to HIV/AIDS effectively involves bringing the areas of society that have the deepest secrets to light in an accepting and non-judgmental fashion, so that governments and non-governmental organizations alike can work to prevent the spread of the virus.

In the case of men who have sex with men, for example, stigma is less likely to allow for monogamous, long-term relationships—inarguably the safest type of sexual relationship in terms of HIV/AIDS transmission—and is instead more likely to promote fleeting sexual encounters, and thus, more sexual partners. In addition, stigma against homosexuality forces many who identify as GLBTQ to enter into heterosexual relationships, despite their natural homosexual identity. This, too, promotes multiple sexual partners, and can result in greater transmission of HIV/AIDS among populations of men who have sex with men.

Another problem created by stigma which exacerbates the problems with HIV/AIDS treatment and prevention is the difficulty for men who have sex with men to seek out and secure HIV counseling and treatment options, including ARTs. Such services often ask probing questions about sexual relationships, in order to establish infection time frames and risk factors for other sexual partners. In the face of discrimination and violence, GLBTQ persons in Kenya generally avoid answering these questions as much as possible.

The Kenya National Commission on Human Rights acknowledged this issue in a report titled “Realising Sexual and Reproductive Health Rights in Kenya: A Myth or Reality?” In it, the governmental department wrote: “In cases where they need medical care, [LGBIs] suffer stigma

perpetuated by health care providers who breach their privacy and confidentiality by exposing their sexual orientation to other colleagues at the facilities. The health care providers are not friendly and hardly understand their sexual and reproductive health needs.”²³⁶

Thus, stigma increases the risk of transmission among men who have sex with men in several ways, simply by preventing access to services. First, it inhibits men who have sex with men from seeking out and understanding proper information about the higher risks of anal intercourse. Second, it prevents men who have sex with men from being tested for HIV and thus many of them do not know their HIV status. Third, it prevents proper collection of data by governmental and non-governmental organizations on HIV rates and transmission among men who have sex with men which, if properly obtained, could aid in preventing the spread of the virus. Then, on top of all of these effects, stigma also prohibits access to proper treatment if and when men who have sex with men become HIV+.²³⁷

Solving the Problem

It is difficult to strategize a way to encourage or promote acceptance of GLBTQ persons and homosexual behavior in Kenya, but there are ways that it might be possible. Change is already coming slowly—it only needs to be sped up.

First, it is imperative that the Catholic Church and other Christian groups take a more active role in promoting the human rights and dignity of GLBTQ persons. As mentioned previously, religious leaders in Kenya are often some of the most outspoken against the rights of GLBTQ persons. Much of this religious stigma comes from selective (and often incorrect) interpretations

²³⁶ Ibid.

²³⁷ Centers for Disease Control and Prevention, “HIV Among Gay, Bisexual, and Other Men Who Have Sex With Men.”

of a few Bible verses found in parts of the Old Testament, and results in wide mistreatment of homosexual people perpetrated by Christian believers. Lay people who attend Christian churches either hear stigma against homosexual behavior from the pulpit, or go along with traditional notions that Christianity denounces homosexuals as human beings. If their religious leaders were to take a more rights-based approach to GLBTQ persons, public opinion could begin to sway.

In a Catholic context, for example, proper interpretation of the church's social teaching inherently demands that the rights and dignity of *all* people, regardless of sexual identity, be respected. This relatively modern attitude toward homosexuality, characterized recently by Pope Francis, does not value homosexual acts intrinsically on the same level as heterosexual intercourse, but nevertheless defends wholeheartedly the dignity of homosexuals and demands the same love for them as any other neighbor. Francis' widely quoted "Who am I to judge?" response to probing questions about gay priests is a prime example of the attitude that can and should be taken among Catholic priests in Kenya.²³⁸

There are other ways to address the issue, as well. Though corruption is difficult to police—which will be discussed in a later chapter on instability—Kenya's police forces can and must do a better job prosecuting police officers who accept bribes or blackmail GLBTQ persons. In 2011, Willie Munyoki Mutunga, the chief justice of the Kenyan Supreme Court stated simply and openly: "Gay rights are human rights... As far as I know, human rights principles that we work on, do not allow us to implement human rights selectively."²³⁹ If a high ranking judge has stated this opinion so openly, the law should begin to apply equally to all Kenyans, regardless of sexual identity.

In addition, NGOs that provide counseling and treatment services should take a more active role in training and educating the workers that they hire on the higher risk of HIV/AIDS among

²³⁸ Alexander Stille, "Who Am I to Judge? Francis Redefines the Papacy," *The New Yorker*, July 30, 2013.

²³⁹ International Federation of Women Lawyers, "Gay Rights are Human Rights," Video, January 31, 2012.

homosexuals and, more importantly, on the value of having a non-judgmental attitude as a care provider. When GLBTQ persons are seen more as human beings and less as barbarians or animals, change will be easier to come by. Caregivers must be the first to make this change if HIV/AIDS is to be controlled among Kenya's GLBTQ population.

This is not to say that every person in Kenya should be convinced that same-sex marriage is acceptable and valuable, or that homosexual partners should have equal rights in marriage to traditional couples. Again, the emphasis here is instead on prevention of the spread of HIV/AIDS, and treatment of the same. Convincing 96 percent of the Kenyan population to change their mind on homosexuality is an impossible task for the short term. Instead, the strategy should be to encourage that they accept the equal human and political rights of GLBTQ Kenyans under the constitution and their own religions, and hopefully greater acceptance will come along later. In the short term, shedding light on the struggles of GLBTQ Kenyans and the stigma they face will begin to reverse the traditional notion that homosexuality is an evil, barbaric practice, and the rate of HIV/AIDS among GLBTQ Kenyans will begin to fall, just as it has in the developed world.

CHAPTER SIX

Poverty

When Westerners describe the problems affecting sub-Saharan Africa, poverty is one of the first that is listed. Indeed, poverty is as present in Kenya as it is in the rest of the region, with 43 percent of the population below the poverty line.²⁴⁰ And although poverty is undoubtedly a problem in and of itself, it also has deep effects on the health and wellbeing of those who struggle with it. When testifying recently before a Senate panel on poverty and its relationship to life expectancy in the United States, Michael Reisch, a professor of social justice at the University of Maryland, made this connection clear: “Poverty is a thief. Poverty not only

²⁴⁰ The World Bank, “Poverty Data: Kenya,” 2014; Central Intelligence Agency. “Kenya.” <http://data.worldbank.org/country/kenya>.

diminishes a person's life chances, it steals years from one's life."²⁴¹ In Kenya, poverty is no different. It not only has direct effects on the standard of living and employment opportunities of those Kenyans who struggle with it; it also poses serious problems for HIV/AIDS prevention and treatment. This section will begin with an analysis of Kenya's current poverty statistics in light of the realities facing those in poverty, based in part on experience in Kibera, the largest urban slum in Africa and one of Kenya's poorest locales. Poverty's relationship with HIV/AIDS prevention and treatment will then be examined, followed by potential interventions that can mitigate poverty's effects on HIV/AIDS prevalence.

Poverty in Kenya

Although Kenya is in many ways considered a role model for the region of sub-Saharan Africa, it nevertheless struggles deeply with poverty and its associated problems. Even with its large and advanced economy—by most assessments, the best in east and central Africa—Kenya still has a Human Development Index (HDI) of 0.519, 145th out of 186 nations in the world which reported data in 2013.²⁴²

The individual statistics for Kenya, predictably, are no better than its HDI. By almost every measure, Kenya falls below worldwide averages and the standards put forth by the UN in its Millennium Development Goals. Kenya has a wildly bottom-heavy population structure—common among developing nations, the product of a high birth rate and short life expectancy—with 42 percent of its population between the ages of zero and fourteen, and 60 percent between

²⁴¹ Annie Lowrey, "Income Gap, Meet the Longevity Gap," *The New York Times*, March 15, 2014.

²⁴² Human Development Index is a statistic that combines life expectancy, education, and income to rank countries according to development. Popularized by Amartya Sen in the early 1990s, modified versions of HDI remain in wide use today, and serve as good indicators of a country's overall development. See: United Nations Development Programme, "The Rise of the South: Human Progress in a Diverse World," *Human Development Report 2013*, 2013.

zero and 24.²⁴³ The life expectancy at birth is 63.52 years, 180th in the world.²⁴⁴ Only 60.9 percent of the population has access to improved drinking water, and 29.4 percent has access to improved sanitation facilities.²⁴⁵ Perhaps most indicative of the nation's deep poverty is the GDP per capita, USD \$1,800, 198th in the world.²⁴⁶ As a result, 38 percent of the population lives in absolute poverty—defined by the World Bank as an income of less than or equal to 1.25 USD a day.²⁴⁷ Most related to the discussion here, Kenya spends only 4.5 percent of its GDP on health expenditures, 151st in the world.²⁴⁸

This poverty is the result of many causes, many of which probably remain unknown. Though the origin of poverty in sub-Saharan Africa is not the focus of this paper, it is important to at least discuss colonialism, which is widely acknowledged as a contributor to this poverty.²⁴⁹ The general mechanism for colonialism's contribution to poverty follows this scheme: First, colonial governors arrived in a particular area, oppressed the population, and began extracting the area's natural resources at an alarming rate. They then took these natural resources and returned them to their home country, where they were processed, manufactured into useful products, and sold to the population there for a massive profit. Perhaps worst of all, in many cases these colonial governors then returned the manufactured goods to the countries from which the natural resources were first taken, selling them to the native populations for an even greater profit. Then, when the native populations rose up and the colony became too difficult to maintain, the colonial governors left the area, leaving behind a damaged infrastructure and a power vacuum over which revolutionaries

²⁴³ Central Intelligence Agency. "Kenya."

²⁴⁴ Ibid.

²⁴⁵ Ibid.

²⁴⁶ Ibid.

²⁴⁷ Martin Ravallion, et al., "Dollar a Day Revisited." *The World Bank*, May 2008, 14, http://www-wds.worldbank.org/servlet/WDSCContentServer/WDSP/IB/2008/09/02/000158349_20080902095754/Rendered/PDF/wps4620.pdf.

²⁴⁸ Central Intelligence Agency. "Kenya."

²⁴⁹ Hallett, Robin. *Africa to 1875*, 65.

would fight violently. In his 1967 encyclical on global development, *Populorum Progressio*, Pope Paul VI acknowledged the negative effect that colonial nations have had on the people they colonized:

It is true that colonizing nations were sometimes concerned with nothing save their own interests, their own power and their own prestige; their departure left the economy of these countries in precarious imbalance—the one-crop economy, for example, which is at the mercy of sudden, wide-ranging fluctuations in market prices. Certain types of colonialism surely caused harm and paved the way for further troubles.²⁵⁰

Once these colonies had been sufficiently exploited, they were continually oppressed under neo-colonialism, which left the nations dependent on their former colonizers yet responsible for their own economic wellbeing. The result was several young nations—of which Kenya was one—which were wildly ill-equipped to handle their own economies and infrastructures. Over time, political conflict and corruption overshadowed the need for investments in healthcare and infrastructure, and the vast majority of the population of these nations fell by the wayside, resulting in the depressing numbers listed above.

These statistics form an extremely long list that, while providing valuable data and a general sense of the problems of poverty, fails to paint the picture clearly. Too often, poverty in sub-Saharan Africa becomes the traditional image—a young child with ribs showing and a swollen belly, dressed in tattered clothes with no family in sight—and the typical numbers: low life expectancy, low income, poor living conditions. But there is a human element to poverty that must not be missed if the problems it creates are to be analyzed and solved effectively.

The human element of poverty in Kenya is perhaps most evident in Kibera. Despite being located in one of the largest and most cosmopolitan cities of sub-Saharan Africa, Kibera remains

²⁵⁰ Paul VI, *Populorum Progressio*, March 26, 1967, I, 7, http://www.vatican.va/holy_father/paul_vi/encyclicals/documents/hf_p-vi_enc_26031967_populorum_en.html.

an area of immense poverty, resulting in a generally low quality of life for its residents. Due to Kenya's extremely high rate of urbanization—in just ten years, the number of Kenyans living in urban areas increased from 24 to 33 percent—Kibera continues to grow with the city around it.²⁵¹ Unfortunately, this growth comes solely in population—not in actual geographic area—resulting in an increasingly higher population density.

Population estimates range widely due to the area's constantly shifting social structures, but the most reasonable estimate for Kibera's population is around 500,000 people.²⁵² In terms of geographic area, though, Kibera is only about two square kilometers, roughly the size of Central Park in New York City.²⁵³ The vast majority of this extremely large, extremely dense population lives in the accommodations typical of urban slums: corrugated metal roofs held up by tree branches and wood planks covered in more corrugated metal. These houses form long, tight rows of accommodation; most residents of Kibera live with their families—which may be as large as eight to ten people—in homes no larger than 10' x 10'.²⁵⁴

These homes, however, are basically used only for shelter at night. During the day, residents of Kibera spend the majority of their time on the street, working and socializing. Many residents commute a few miles to the city center to work as shopkeepers, salesmen, or tour guides. Others work closer to home, selling food, homemade jewelry, or clothing in the nearby Toi Market.

²⁵¹ Annabel Erulkar, et al., "Adolescence in the Kibera Slums of Nairobi, Kenya," *Population Council*, 2007, iv.

²⁵² *Ibid.*, p. 2.

²⁵³ *Ibid.*

²⁵⁴ During my time in Kibera, I was invited to spend time in the homes of two of my students. One student's family had saved enough money to move to a nicer area of the slum. His neighborhood, on the northwest end of Kibera, had better access to water and sanitation facilities than the area where most of the students live, but it nevertheless provided a stark contrast to the types of accommodations common in the developed world. This student's entire family—him, his uncle and aunt (who had adopted him), and three of his cousins—lived in a small, two-room structure. The total area was probably smaller than 200 square feet, and was home to a goat and two chickens as well. Another student lived in the heart of the slum, near the river. His home was constructed only of corrugated metal and wooden sticks, and had no furniture beyond two thin mattresses along the floor, which he shared with his adopted mother and his two sisters.

Still others own shops in Kibera, which range from butcher's shops to cell phone stores to pharmacies. The majority of these stores are run out of the same corrugated metal buildings in which residents live, forming continuous streets of stores that some residents call "malls."

The problem with owning a store, however, is the high rate of theft in Kibera. In order to prevent robbery, store owners often pack up all of their wares at the end of the day and carry them home in a large sack, only to return the next day to set up the entire store again. Alternatively, many shop owners simply opt to sleep in their store each night, in order to stand guard over the few possessions they hope to sell the next day. These shop owners are not being overprotective—the crime rate in Kibera is extremely high, with thefts, muggings, assaults, and rapes occurring daily.²⁵⁵ In part, this is due to Kibera's extremely high unemployment rate, which is near 50 percent and leads to idleness and drug and alcohol abuse. Particularly at night, Kibera remains one of the most unsafe areas in the world. As such, the majority of residents stay home from sunset to sunrise.

Although the unemployment rate is high, the initiative, ambition, and work ethic of Kibera's residents is not lacking.²⁵⁶ In an area where so few residents have disposable income, it is simply hard to find employment that is stable and sustainable. Despite (or perhaps because of) this, *The Economist* has said that Kibera "may be the most entrepreneurial place on the planet." In the piece, the author provides a variety of examples of the initiative and economic activity of

²⁵⁵ Living as an outsider in Kibera makes one particularly vulnerable to crime. During my own time there, I never stayed out in the slum past dark without being accompanied by a Kenyan, and often felt unsafe even during daylight hours. I was only robbed once, but the experience taught me a great deal about the slum. When I spoke with my Kenyan friends about it, they were not surprised in the slightest. Many Kenyans, they said, see stealing from Westerners as a daily part of life that helps to right the vast income inequality they know exists in the world. In some ways, I agree.

²⁵⁶ While working at St. Aloysius, one of the roles I took on was working with students to compose letters that they were writing to sponsors in the United States who pay for their school fees. One student wrote in his letter about Ken Okoth, who spoke to the students at St. Al's day, an annual celebration of the school and the students' accomplishments in late June. Okoth was born in the slum, received sponsorship through secondary school, earned a scholarship to Georgetown University in the United States, returned to Kenya afterward, and became Kibera's MP in the Kenyan Parliament. In that letter, the student wrote that Okoth's story made him understand that "in the path of life, you won't be measured by the humbleness of your beginning but by the greatness of your finish." Ambition is certainly not lacking, particularly among the students at St. Aloysius.

Kibera's residents, which range from charging for the use of privately owned toilets, to providing safety escort services in the evenings, to offering television to people walking by, for a price. In the words of the article: "To equate slums with idleness and misery is to misunderstand them... Robert Neuwirth recalls that New York's Upper East Side was once a shantytown and suggests that all bright shining cities start as mud. Slums are far from hopeless places; many are not where economic losers end up, but rather reservoirs of tomorrow's winners."²⁵⁷

Access to fresh drinking water in Kibera is rare, and residents often walk long distances to access water that has been filtered and cleaned. Although a river runs through the center of the slum, it is highly polluted with trash and animal and human waste. The few water pumps that do exist—a recent development in Kibera—provide the drinking water for all of the residents of the area, and often have extremely long lines.

Sanitation facilities in Kibera are perhaps even more uncommon than fresh drinking water. Almost none of the homes in Kibera have proper toilets, and most lack even basic sanitation facilities. During the day, residents often travel to public toilets, which they can use for the price of about ten shillings (USD \$0.12).²⁵⁸ Because leaving home during the night is so dangerous, many Kibera residents use plastic bags in the night, and throw the used bag out the door, as far as possible from their home. These "flying toilets" are well known among Kibera residents, and though young Kenyans often joke about them, they serve as an indicator not only of the oppressively high crime rate, but also of the poorly developed sanitation systems. Plastic bags, whether used for human waste or other trash, form a large majority of the pollution in Kibera, covering the streets and the surface of the river.

²⁵⁷ The Economist, "Boomtown Slum: A Day in the Economic Life of Africa's Biggest Shanty-Town," December 22, 2012.

²⁵⁸ Ibid.

It is obvious that poverty like that observed in Kibera affects access to quality healthcare. Indeed, despite the efforts of hundreds of NGOs and the Kenyan government, health standards and life expectancy in Kibera fall well below the national average. Many health-related NGOs that operate in Kibera, including Médecins sans Frontières (Doctors Without Borders), provide health counseling and treatment to residents of the slum. These clinics, though rudimentary, provide treatment for malaria, HIV/AIDS, and other infectious diseases, as well as counseling and support for victims of rape and sexual abuse. HIV/AIDS testing is widely provided in Kibera, and more than 70 percent of young people know where to go to get tested, according to a 2006 study.²⁵⁹ Improvements have been particularly impressive in the last ten years, when the number of clinics in Kibera saw a massive increase, according to residents. Indeed, even some of Kibera's poorest residents now have access to life-saving treatments like malarial medication and ARTs through free clinics funded primarily by NGOs.

On the surface level, daily life in Kibera shares little in common with the typical day of a Westerner. Unlike most of the residents of Kibera, the vast majority of Americans have adequate access to toilets and running water, and even though the healthcare system is far from perfect, most are able to obtain the medical treatments they require. Yet at the same time, Kibera's residents have the exact same goals as their counterparts 7,000 miles away. They want to provide for the health and wellbeing of themselves and their families by ensuring adequate food, shelter, medicine, and protection. They want to have a rewarding job that compensates them adequately for the labor they perform, and which applies their skills and satisfies their intellect. Above all, they want to live healthy, productive, and prosperous lives. Unfortunately, it is much more difficult to succeed in all of these goals in Kibera than it is in the United States.

²⁵⁹ Erulkar, et al., vi.

HIV/AIDS and Poverty

Much as the previous sections sought to explain the role that a particular ethical issue plays in HIV/AIDS prevention and treatment, this section seeks to do the same with poverty. It is important to remember, particularly in the case of poverty, that this is a two-way street—while poverty affects the HIV/AIDS epidemic, the reverse is also true. Any potential solution for one, then, can and will contribute to the other. This fact makes addressing HIV/AIDS in Kenya all the more important, because it can serve not only to save the lives of those afflicted by the virus, but also to mitigate the deep poverty with which citizens of the nation, regardless of their HIV status, constantly struggle.

There are many obvious ways in which poverty affects HIV/AIDS prevention. One such way is by restricting and limiting access to education. It is a widely cited fact that is well-supported by research that those who are more educated—particularly but not necessarily about HIV/AIDS and associated risky behaviors—are less likely to contract and transmit HIV.²⁶⁰ Yet poverty inevitably discourages education. In many cases, families cannot afford school fees for their children to attend secondary school and, in most cases, tertiary education is not an option at all. And while primary education is free, many potential students are kept at home in order to work and support their family or their family's business. Education is a luxury of the world's rich—those who are intensely poor simply do not have the funds to be able to sacrifice their children's time and abilities.

In addition, poverty makes it far less likely that preventative measures like condoms will be employed adequately in risky sexual encounters. When families are struggling to finance their

²⁶⁰ Anne Bakiiana, et al., "Accelerating the Education Sector Response to HIV/AIDS in Africa: A Review of World Bank Assistance," *The World Bank*, 2005, ix; Alexandria Valerio and Don Bundy, "Education and HIV/AIDS: A Sourcebook of HIV/AIDS Prevention Programs," *The World Bank*, 2003.

children's education or their next meal, the disposable income to spend on condoms simply does not exist. As an example of poverty's effects on condoms and HIV/AIDS prevention, consider a 2011 report that men in rural parts of Kenya were washing their condoms, hanging them out to dry, and reusing them:

Local TV channels recently showed images of men in Isiolo, in rural northern Kenya, washing condoms and hanging them out to dry; the men said the price of condoms meant they could not afford to use them just once. Other men in the village said when they had no access to condoms, they used polythene bags and even cloth rags when having sex.²⁶¹

Even if Kenyans do have the income available to purchase condoms, there may not be any available. Condom production in Kenya falls far below demand, and as such many condoms are imported or received as part of international aid. In 2011, Kenya's Ministry of Health appealed to the United States to provide 45 million condoms through PEPFAR in an effort to control HIV transmission.²⁶² The same report indicated that demand for condoms more than doubled from 2004 to 2011, from eight million per month to 20 million per month, according to the Ministry of Health. Yet during those years, only about seven million condoms were distributed monthly.²⁶³ Other preventative procedures (e.g., circumcision) have traditionally been expensive as well, though recent work by NGOs have made these far more accessible.

Poverty not only affects prevention, however. It also affects treatment. Those who are poor are less likely to be able to obtain ARTs and are more likely to have an unstable living situation. Unstable living situations often make ARTs less effective, because the strict regimen of drug intake can be easily interrupted if a patient has to move frequently, has unstable employment, or is unable

²⁶¹ IRIN, "Kenya: Condom Recycling Highlights Gaps in HIV Prevention Programming," *UN Office for the Coordination of Human Affairs*, March 29, 2011.

²⁶² Ibid.

²⁶³ Ibid.

to provide the necessary funds for treatment. Access to ARTs and other AIDS-related pharmaceuticals will be discussed at greater length later in this paper.

Solving the Problem

Of all the ethical issues discussed here, the solutions for the mitigation of poverty are perhaps the most likely to be effective, for several reasons. First, unlike gender inequality and stigma against homosexuality, poverty is not a topic on which people in Kenya often disagree. In other words, there is no internal social debate about whether or not poverty should exist—it is simply understood that it is an inherent evil, a form of structural violence that ought to be eradicated. This means that, though it remains a difficult issue to resolve, at least the world is united against it.²⁶⁴ Second, a related point is that solutions to poverty will not depend so strongly on changing an entire society's conscience as those which seek to solve gender inequality or stigma against homosexuality—these are changes that can be implemented regardless of public opinion or traditional practices. Third, poverty is a problem that, more than any of the other issues discussed here, is already being addressed by the global community and has been continually addressed for many decades.

While efforts to eradicate poverty so far are noble and have been effective in some areas, a simple look at Kibera makes it obvious that more can be done. Greater financial support of NGOs and CBOs which provide direct medical care—either by supplying the population with ARTs, performing voluntary circumcisions, or providing VTC—can help to provide access to these

²⁶⁴ There are many theories that the developed world (e.g., the United States) has a vested interest in ensuring that poor countries stay poor, and that international aid is just a public relations façade. The argument is based, in part, on the exploitation of poorer countries by richer countries for natural resources and cheap labor. One would hope that these are conspiracy theories rather than legitimate analysis of political conditions. Either way, international aid will be discussed in the next section.

services regardless of a person's income level. When every resident of Kibera can obtain access to VTC for free, for example, HIV prevention in the area will become much easier. In many cases, HIV+ Kenyans are not willingly engaging in risky behaviors—they simply do not know that they are HIV+. Hosea Mutoro, a Kenyan interviewed on why he recycled condoms, was one who was lucky enough to know his HIV status, and it made a direct impact on his behavior: “I know I am [HIV] positive but I don't want to give my wife HIV and I know if I use a condom, she is safe.”²⁶⁵ This simple account provides anecdotal evidence that VTC works to mitigate transmission. Once a person knows that they are HIV+, they will, in general, behave in a safer and more responsible manner towards their sexual partners.

But the international community can and should take investments in medical care and VTC one step further. As mentioned previously, often what prohibits at-risk populations from obtaining adequate education or medical services in relation to HIV/AIDS is not necessarily the cost, because many of these services are already provided free of charge through NGOs and CBOs. Rather, it is the time that they must give up to obtain these services, which could otherwise be used to operate a store or sell goods in the market, thus generating income for their family and helping to ensure financial security. In order to provide incentives for at-risk populations (e.g., the residents of Kibera) to obtain VTC, CBOs and NGOs should consider providing additional goods to those who take advantage of these services and determine their HIV status.

Critics of this approach make several arguments: first, that it is too expensive; second, that it might be abused by people who take advantage of the system and attend repeatedly. Admittedly, such a strategy would be more costly for the organizations and could result in some people taking

²⁶⁵ Ibid.

advantage of the system, but the benefit of an entire population knowing their HIV status far outweighs these consequences in terms of HIV prevention.

The downside of working to mitigate poverty is that it is like using a hand pump to drain a lake—the magnitude of the problem is so large, that any interventions seem impossibly small and ineffective. Yet just like the value of CBOs mentioned previously, programs that work to mitigate poverty by providing goods and services to those in poverty have value because they make tangible differences in the lives of individuals, while making slow but steady progress in the direction of large-scale change. Certainly providing VTCs to Kenyans in Kibera will not end world poverty, but it will allow thousands of at-risk Kenyans to know their HIV status, which in turn can lead to safer sexual practices and a lower rate of HIV, which can produce a healthier, more productive workforce. In the case of poverty, the cogs are lined up. The international community simply needs to start turning them a little faster.

CHAPTER SEVEN

Instability and International Aid

In their 2014 annual letter, Bill and Melinda Gates set out to dispel three myths that they argued “block progress for the poor.”²⁶⁶ Among these myths was the premise that foreign aid is a wasted investment, a view that they argued is currently held by the majority of citizens in developed nations. In the letter, Bill Gates cited a widely-discussed poll that asked Americans what portion of the annual federal budget they thought goes to foreign aid.²⁶⁷ On average, Americans responded “25 percent.”²⁶⁸ When asked how much they thought the government should spend on

²⁶⁶ Bill and Melinda Gates, “The 2014 Gates Annual Letter: Three Myths that Block Progress for the Poor,” *The Bill and Melinda Gates Foundation*, January 2014.

²⁶⁷ Kaiser Family Foundation, “2013 Survey of Americans on the U.S. Role in Global Health,” Conducted August 6-10, 2013.

²⁶⁸ More precise data indicates that the number is actually 28 percent (see the next footnote).

aid, Americans on average responded “10 percent.”²⁶⁹ The reality is that the United States spends less than one percent of its budget on international aid, and Norway, the world’s most generous nation, spends only about three percent.²⁷⁰ Of that less than one percent of the American budget that goes to foreign aid, only about a third is spent on health (e.g., vaccines, drug regimens, etc.).²⁷¹ These numbers provide the ground for a very interesting discussion on the attitudes of the world’s richest citizens toward international aid. In general, Americans think that the U.S. should spend far more than it already does on international aid, yet at the same time, their estimates of current spending are way off the mark. Does that mean more spending on foreign aid is justified? Are richer nations morally obliged to do so? This section will address international aid—as well as the political instability which is often cited as a justification against that aid—as ethical issues in the context of the HIV/AIDS epidemic.

Instability and International Aid in Kenya

One might ask why this section puts together two topics—political instability and international aid—which seem to be easily separated. The justification is that political instability has direct effects on international aid. In country-to-country foreign relief, for example, the government of the receiving nation is often responsible for the handling and implementation of that aid. As such, political instability is often seen as a deterrent to international aid, because it so often results in corruption and inefficiency that ensures that the money—paid for by Western tax dollars—ends up in the wrong hands. Recent examples of this phenomenon come in the wake of

²⁶⁹ Ezra Klein, “The Budget Myth that Just Won’t Die: Americans Still Think that 28 Percent of the Budget Goes to Foreign Aid,” *The Washington Post*, November 7, 2013.

²⁷⁰ Gates. “The 2014 Gates Annual Letter: Three Myths that Block Progress for the Poor.”

²⁷¹ These figures exclude financial aid to foreign militaries. The remaining two thirds is generally spent on infrastructure developments like bridges, wells, roads, etc.

the Arab Spring, when media outlets like Fox News criticized the U.S. role in administering foreign aid in places like Egypt and Libya, where large amounts of U.S. money ended up in the hands of brutal, totalitarian dictators.²⁷² In large part, these concerns are legitimate, and foreign aid deserves scrutiny from the taxpayers who provide it. Yet it is foolish to take the Libyan militocracy bent on suppressing revolts as the point and case against all foreign aid. Nevertheless, political instability like that during the Arab Spring is inextricably tied to international aid and investment on behalf of foreign nations. Beginning with a brief summary of Kenya's own experience with instability, this section will analyze international aid in Kenya and posit ways in which both of these issues have affected HIV/AIDS prevention and treatment.

Kenya's history of political violence and instability dates back even before its independence. As the brief summary of Kenya's history above indicated, the struggle for power in Kenya is centuries old. Beginning with battles between the Portuguese and the Omani Arabs in the 16th and 17th centuries, political violence in Kenya reached a fever pitch during the last days of British colonialism there. Kenyan rebels, led politically and intellectually by Jomo Kenyatta, committed many atrocities, murdering white settlers and regional governors. At the same time, Kenyans were the victims of serious violence perpetrated by their British colonizers, who exploited them for inexpensive labor and natural resources. The Mau-Mau Uprising, as the Kenyatta-led movement was called, was the most successful violent rebellion against colonial rule in Africa, and resulted directly in Kenya's independence less than a decade later.²⁷³

Yet independence did not end the political violence, and perhaps even exacerbated it. Like the majority of the continent, Kenya escaped colonial rule in the early second half of the 20th

²⁷² William la Jeunesse, "Did Qaddafi Deserve U.S. Funding? Foreign Aid Under Scrutiny Amid Mideast Unrest," *Fox News*, March 24, 2011.

²⁷³ BBC News, "A Chronology of Key Events."

century. With the departure of colonial governors, Kenyans were left to handle their affairs on their own terms. Unfortunately, they were—like many of their neighbors—woefully ill-equipped. The nation relied heavily on support from the British colonial government to maintain and operate the nation's infrastructure. As an example, upon the departure of the British governors, the railroad from Mombasa to Kampala fell into disrepair and became unreliable and unusable.²⁷⁴ Even today, the railroad is wildly unpredictable and unsafe. With the departure of colonial rulers also came a departure of the technology they brought with them and the support systems that had allowed that technology to function.

In addition to leaving behind logistical problems, the departure of Great Britain from Kenya resulted in a power vacuum that was quickly filled by Jomo Kenyatta and the Kenya African Union. Once the vacuum was filled, however, it needed to be maintained. Kenyatta retained what was essentially totalitarian rule over Kenya not by acting as a benevolent leader who saw to the needs of his people, but rather by quashing out rebellions and political challenges as quickly and brutally as possible.²⁷⁵ Though the accusations were never precisely confirmed, many international authorities argue that Kenyatta's security forces were responsible for the deaths of a variety of dissidents, including journalists and politicians.²⁷⁶ In addition, he banned other political parties, arrested the leaders of them, and won several "elections" as the only candidate on the ballot.

When Daniel arap Moi took over the presidency in 1978—which essentially provided him dictatorial powers—he continued his predecessor's habits. His regime violently put down a coup

²⁷⁴ Ibid.

²⁷⁵ Gerard Prunier, "Kenya: Roots of Crisis," *Open Democracy*, January 7, 2008.

²⁷⁶ Wanyiri Kihoro, "Politics and Parliamentarians in Kenya: 1944-2007," *The Centre for Multiparty Democracy* (Nairobi: Lino Typesetters, 2007), 13.

by the military, was accused of receiving bribes, and was proved by the UN to be guilty of human rights abuses and inciting political and ethnic violence.²⁷⁷

More recently, Kenya has continued to struggle with violence and instability. In the last 15 years, Kenya has been the victim of increasingly frequent terror attacks perpetrated by Somali nationals and Islamic extremists. These include the 1998 Al Qaeda attack against the American embassy in Nairobi, grenade attacks by Somali Muslims in 2011 and 2012, and the Westgate Mall shooting in the fall of 2013.²⁷⁸ The total number injured by these attacks now reaches into the thousands. In addition to the terror attacks, ethnic violence following the 2007 election, mentioned briefly above, brought significant negative attention on Kenya from the international community.²⁷⁹

What effect has this violence had on international aid to Kenya? Francis Mwega, an associate professor of economics at the University of Nairobi, acknowledged that foreign aid has been increasingly criticized during the start of the 21st century.

The last decade or so has, however, seen a radical criticism of foreign aid. This has been driven by the perception that foreign aid has not produced the desired or expected results...Where the economic and political environment is right, it can be

²⁷⁷ Internal Displacement Monitoring Center, "Prominent Party Politicians of the Former Government Have Fueled Incidents Along Ethnic Clashes in Kenya Since 1991."; U.S. Department of State, "Kenya 2012 Human Rights Report," *Bureau of Democracy, Human Rights, and Labor*, 2, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm?year=2013&dld=220124#wrapper>.

²⁷⁸ Brian Bennett. "Al Qaeda Operative Key to 1998 U.S. Embassy Bombings Killed in Somalia"; Edmund Blair, "Islamists Claim Gun Attack on Nairobi Mall, at Least 39 Dead," *Reuters*, September 21, 2013; David Clarke, "Nairobi Bus Station Blast Toll Rises to Five: Red Cross," *Reuters*, March 11, 2012.

²⁷⁹ Speaking with Kenyans about the 2007 elections violence is an interesting experience. On the one hand, they acknowledge openly that it was a low point for the country, and that many people were killed and injured who should not have been. Yet despite progress with a coalition government, almost all of the Kenyans I spoke to felt that the action their particular tribe had taken was justified. Kikuyus that I spoke with were certain that Kibaki's election was fair and that his swearing in at night was solely for his own safety, and that their tribe was victim—not perpetrator—of the violence afterward. Luos that I spoke with, on the other hand, felt that the violence perpetrated against Kikuyus was not only deserved, but was also effective. After all, the coalition government did result in some changes that the non-Kikuyu tribes saw as amenable. With the most recent election, Luos remain unhappy with the election of Uhuru Kenyatta, but they at least acknowledged that the election was fairer.

very helpful in supporting economic and social progress. Where it is not, it will have no positive effect and will be wasted at best.²⁸⁰

He also provided a brief summary of foreign aid to Kenya, which paints a picture that shows some of the reasons why aid might not be as effective as it could be.

In his comprehensive report on aid to Kenya, Mwega shows that the historic high for aid to Kenya was in 1989-90, when Kenya received USD \$1.6 billion (in 2006 dollars).²⁸¹ Development aid took an erratic course throughout the following decade, at times increasing, at times decreasing. In 2006, official development assistance (ODA) to Kenya totaled USD \$943 million, 23rd among 150 developing countries receiving aid.²⁸² Overall aid trends from 1993 to 2006 saw a decrease in aid to Kenya, “with two major episodes of ‘aid freeze’ and donor withdrawals as the government reneged on its commitment to donors.”²⁸³ Since 2003, aid to Kenya has steadily increased.²⁸⁴

This type of trend is perfectly illustrative of the effects that political instability can have on international aid. In the 1990s, then-President Moi was under pressure from the international community to permit additional political parties and ease his restrictions on the nation’s press. He was also widely accused of inciting ethnic violence in order to ensure his reelection. During this time of political instability and conflict, international aid to Kenya decreased greatly—from 1991

²⁸⁰ Francis Mwega, “A Case Study of Aid Effectiveness in Kenya: Volatility and Fragmentation of Foreign Aid, with a Focus on Heath,” *The Brookings Institution*, January 2009, 1.

²⁸¹ Ibid.

²⁸² Ibid. ODA is a term coined by the Organization for Economic Cooperation and Development in 1969, and is used as an indicator of international aid flow. It essentially totals all investments by a foreign nation that have economic development or social welfare as the end goal.

²⁸³ Ibid.

²⁸⁴ In general, Kenyans have highly favorable views of the United States, which serves as a key ally and international donor. At St. Aloysius, students speak often about “well-wishers”—the donors that they know help pay for the maintenance and operation of their school. During my time there, I spent time working with the students on the thank you notes that they write biannually to private American citizens who pay for their fees at school. The children were universally and genuinely grateful for the sponsorship from Americans, and their letters overflowed with that sentiment.

to 1999, ODA to Kenya fell by 60 percent.²⁸⁵ On the other hand, since the nation has become more politically stable following the 2007 elections violence, aid to Kenya has increased to pre-1991 levels. This relationship between political instability and less foreign aid is not just a coincidence.

Interestingly, recent international aid to Kenya has come in large part from China, as indicated by Figure 6, below, which shows the rapid increase in Chinese investment since 2004 that continues to grow today.

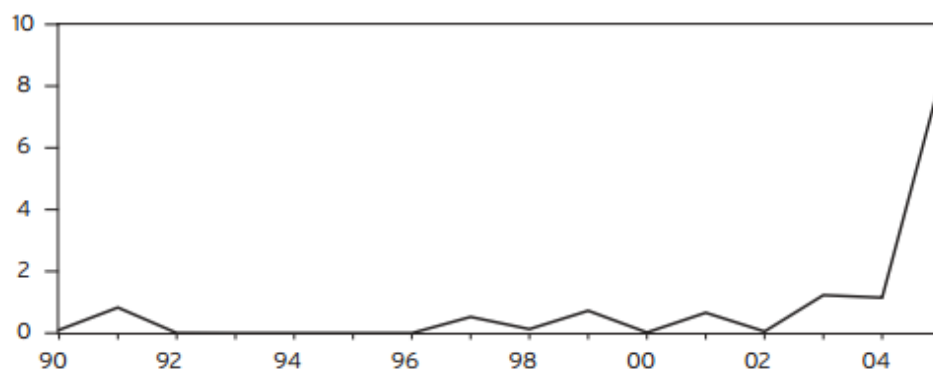


Figure 6. Percent share of Chinese foreign aid to Kenya from 1990 to 2006.²⁸⁶

In 2013, Liu Guangyuan, the Chinese ambassador to Kenya, posted a statement on behalf of the Chinese government which indicated China's dedication to development in Kenya publicly. "China-Kenya economic cooperation and trade is on a strong momentum," he wrote. "By June this year, China's cumulative direct investment in Kenya had reached USD \$474 million. The bilateral trade volume reached USD \$2.84 billion last year. China has become Kenya's largest source of foreign direct investment and second largest trade partner."²⁸⁷ In 2013, Chinese investments in Kenya's infrastructure were obvious in Nairobi. Construction projects sponsored by Chinese

²⁸⁵ Ibid.

²⁸⁶ Ibid.

²⁸⁷ Liu Guangyuan, "Kenya and China Achieving Shared Dreams Hand-in-Hand," August 16, 2013. http://www.capitalfm.co.ke/eblog/2013/08/16/kenya-and-china-achieving-shared-dreams-hand-in-hand/?wpmp_switcher=mobile.

companies continue to crop up all over the city, with a great deal of that investment coming in infrastructure upgrades to communication and transportation systems.²⁸⁸

The effectiveness of aid, on the other hand, is far more difficult to quantify than the amount of aid Kenya is receiving. In general, disbursement of international aid in Kenya is not outstanding. According to a 2005 report, disbursement ratios for ODA were 57 percent for grants and 70 percent for loans.²⁸⁹ According to Mwega, these low percentages are the result of several factors, including “long and bureaucratic delays in tendering procedures; poor reporting and accounting for funds utilized; and failure by the government to meet upon obligations such as counter-funding once commitments are signed for.”²⁹⁰ These low percentages are also simultaneously the result and cause of the aid volatility that Kenya experiences—the nation might receive more aid than it expected, for example, and then have difficulty disbursing it, which in turn leads to a poor disbursement ratio and a decrease in international aid in the following years. The result is a perpetual cycle of different amounts of aid from year to year, rather than a steady provision of it.²⁹¹

In general, there are two models of international aid that are widely referenced—the donor interest model and the recipient need model.²⁹² On the one hand, the donor interest model argues that the most significant motivator in the provision of international aid is not the need of the country receiving the aid, but the strategic goals of the country providing the aid. This type of

²⁸⁸ Sudarsan Raghavan, “In Snub to Washington, Kenyan President Visits Russia, China First,” *The Washington Post*, August 17, 2013. Public perception of Chinese investment in Kenya is mixed. On the one hand, it appears beneficial because it creates jobs while improving the nation’s infrastructure. On the other hand, many Kenyans have strongly negative attitudes towards Asian immigrants, who they argue are taking employment opportunities that rightfully belong to Kenyans. In fact, Chinese migration to Africa has swelled recently, and many reports do show that native Africans are losing jobs to immigrants. Other arguments against Chinese investment are that their projects are solely in the interest of China and its citizens (e.g., removing valuable minerals), and that once these tasks are completed, the infrastructure will quickly fall apart as it did after the British empire lost interest.

²⁸⁹ Mwega, 11.

²⁹⁰ *Ibid.*, 12.

²⁹¹ *Ibid.*, 10-12.

²⁹² R. D. McKinlay and R. Little, “A Foreign Policy Model of U.S. Bilateral Aid Allocation,” *World Politics* 30 no. 1 (1977): 58-86.

international aid is exemplified best by the United States during the Cold War, when significant foreign aid was provided under the Truman Doctrine specifically to contain the spread of communism.²⁹³ In this case, rather than addressing the serious problems in the nations receiving aid, foreign aid instead went directly to projects that could help prevent the spread of communism, like military investments and technological upgrades.

The recipient need model, on the other hand, argues for international aid based purely on the needs of the receiving country.²⁹⁴ In the case of a nation struggling with significant famine, for example, aid under the recipient need model would provide directly for food assistance and agricultural upgrades. In the case of HIV/AIDS, recipient need foreign aid would focus on education, providing ARTs and VTC, and creating support networks for people living with HIV/AIDS. While it is obvious that the recipient need model is more effective at responding directly to the problems facing recipient nations, it nevertheless is dwarfed by donor interest international aid today.²⁹⁵ Changing this status quo will be imperative in improving the effectiveness of international aid, and, transitively, the lot of the world's poorest nations.

In relation to this paper's topic of HIV/AIDS, the health-related expenditures of ODA in Kenya are surprisingly low. From 1980 to 2006, Kenya spent only 5.6 percent of ODA on health, increasing over time to a peak of 9.2 percent from 2000 to 2006.²⁹⁶ In large part, this increase was due to the widespread effects of the HIV/AIDS pandemic and the slow realization on Kenya's part to address it.

²⁹³ Ibid.

²⁹⁴ Ibid.

²⁹⁵ Ibid.

²⁹⁶ Mwega, 29.

Fortunately, corruption is not a large deterrent to international aid in Kenya, and contributes only in small amounts to the poor disbursement of funds.²⁹⁷ This is in large part due to Kenya's increasingly stable and democratic government, which oversees international aid better today than it has in the past. Even in cases where corruption is present, public perception is often skewed on how much of an issue fraud really is. In his annual letter, Bill Gates writes:

One of the most common stories about aid is that some of it gets wasted on corruption. It is true that when health aid is stolen or wasted, it costs lives. We need to root out fraud and squeeze more out of every dollar. But we should also remember the relative size of the problem. Small-scale corruption, such as a government official who puts in for phony travel expenses, is an inefficiency that amounts to a tax on aid.²⁹⁸

In the long term, this "tax" on aid provides only a small argument against continuing and even growing the amount of money that is provided to the developing world, which desperately needs any help it can get. As Gates writes, "Suppose small-scale corruption amounts to a 2 percent tax on the cost of saving a life. We should try to reduce that. But if we can't, should we stop trying to save lives?"²⁹⁹

HIV/AIDS, Instability, and International Aid

The effects of instability on HIV/AIDS prevention and treatment are quite easy to understand in a common sense fashion. For large-scale problems like epidemics, the population of a country depends on their government to provide large-scale responses. During an HIV/AIDS epidemic, for example, the government shares a large part of the responsibility for adjusting education programs to address the issue, providing prevention plans to schools, workplaces, and relevant agencies, and providing drug regimens and other treatments to those affected. When

²⁹⁷ Ibid., 15.

²⁹⁸ Bill and Melinda Gates, "The 2014 Gates Annual Letter: Three Myths that Block Progress for the Poor."

²⁹⁹ Ibid.

governments are hindered by political conflicts, ethnic violence, or terrorist attacks, they are less able to allocate the correct funds, manpower, and legislation towards the issues that truly deserve their attention.

At the same time, when a nation's political leaders are concerned only with maintaining power and do not have impending democratic elections, they are less likely to focus on helping their constituents. Such has been the case in Kenya. From independence through recent years, Kenya's political leadership has relied on brutal tactics of oppression and suppression to maintain political power, inciting ethnic violence and killing political opponents whenever it became helpful. The elections that were held from the time of Jomo Kenyatta through the presidency of Daniel arap Moi, and even as recently as the 2007 election, have been marred by violence and criticized by the global community as barely democratic. Without a real constituency to answer to, the issues of the public are only nominally the concern of the political leadership. HIV/AIDS is a good example of such an issue, only being forced to the forefront and begrudgingly acknowledged by President Moi after years of deaths and a prevalence rate of nearly ten percent.

While the effects of Kenya's instability on HIV/AIDS prevention and treatment is relatively obvious, the implications of international aid on the epidemic are more nuanced. As the health-related ODA data above indicate, the amount of international aid dedicated to health has increased steadily since the 1980s. It is no coincidence that this trend began around the time of the discovery of HIV/AIDS, and peaked along with the virus in the 1990s. International aid to sub-Saharan Africa over the past 30 years has been closely tied to the fight against HIV/AIDS.

Perhaps the best example of this trend is PEPFAR, the U.S. President's Emergency Plan for AIDS Relief, which was initiated by President George W. Bush in 2003 and has since been widely celebrated by both Republicans and Democrats as one of the greatest successes of his

presidency.³⁰⁰ By almost all accounts, PEPFAR has saved or extended literally millions of lives in sub-Saharan Africa by providing funding for education programs, prevention programs, and drug regimens to those living with HIV/AIDS.³⁰¹

In Kenya alone, PEPFAR has provided billions of dollars specifically for HIV/AIDS relief. In 2004, the program began by providing Kenya USD \$92.5 million.³⁰² That number increased steadily over the following years, peaking at USD \$565 million in 2009.³⁰³ In total, from 2004 to 2011, PEPFAR has provided nearly USD \$3 billion to Kenya, specifically for HIV/AIDS relief.³⁰⁴ In general, the program has seen great success.

Since the inception of PEPFAR through 2011, the program has allowed 493,000 people to access ARTs and has supported more than 1.5 million HIV+ Kenyans, of which 558,000 were orphans and vulnerable children. Perhaps most importantly, PEPFAR has provided nearly 7.5 million people with access to VTC, vastly improving the public's knowledge of HIV status. In order to help prevent mother to child transmission, PEPFAR has provided more than 1 million pregnant women with support, including providing 67,000 HIV+ pregnant women with ARTs, averting an estimated 20,000 infant HIV infections.³⁰⁵

PEPFAR is an example of the great success that international aid can have in responding to the HIV/AIDS crisis. The amount of money being pledged is extremely high, but the results speak for themselves. Yet PEPFAR has not been flawless, and much criticism has been lodged against the way in which funds are spent. In general, the program does not release data on how the

³⁰⁰ AVERT, "President's Emergency Plan for AIDS Relief," accessed March 25, 2014.

³⁰¹ U.S. Department of State, "Partnership to Fight HIV/AIDS in Kenya," *The President's Emergency Plan for AIDS Relief*, 2013, <http://www.pepfar.gov/countries/kenya/>; Lancet Editorial Staff, "Appointment of PEPFAR Head Should Be Merit Based," *The Lancet* 373 no. 9661 (2009): 354.

³⁰² U.S. Department of State. "Partnership to Fight HIV/AIDS in Kenya."

³⁰³ Ibid.

³⁰⁴ Ibid.

³⁰⁵ Ibid.

money that is being pledged is spent, which has led to widespread criticism by policymakers and other stakeholders.

When data is released, however, it is scrutinized closely and often criticized. For example, data indicate that from 2004 to 2006, only eleven percent of PEPFAR funds went to community-based organizations.³⁰⁶ The vast majority of funds were instead provided to large international NGOs that, while able to effect change on a large, structural level, are generally less able to respond directly to the needs of individuals in nations struggling with the HIV/AIDS epidemic. Percent funding for local CBOs has increased as PEPFAR has grown, with a larger share of funding each year being reserved for smaller, indigenous organizations.³⁰⁷ Other critics argue against initial earmark requirements for PEPFAR that necessitated that a certain amount of funding be used to teach the value of abstinence before marriage in preventing transmission of HIV/AIDS.³⁰⁸

When discussing HIV/AIDS and its relationship to instability and international aid, there are a few points that should come as major takeaways. These points are supported by a wide array of data and organizations, from AVERT to the U.S. Department of State to the Gates Foundation. First, aid works in almost every way it is intended to, despite the typical arguments against it. Nations that receive aid are better able to respond to the problems they face, better able to provide a higher standard of living for their citizens, and in time become self-sufficient and stable as a result of that aid. The many nations that have essentially “graduated” from foreign aid—among them, Brazil, Botswana, Morocco, Mexico, Chile, etc.—are evidence of this fact.³⁰⁹ Second, political instability makes aid less effective, but it does not make it ineffective. In the same way

³⁰⁶ Nandini Ooman, et al., “New PEPFAR Data: The Numbers Behind the Stories,” *Center for Global Development*, April 17, 2008.

³⁰⁷ AVERT, “President’s Emergency Plan for AIDS Relief.”

³⁰⁸ Dean Jamison and Nancy Padian, “Where AIDS Funding Should Go,” *The Washington Post*, May 20, 2006.

³⁰⁹ Bill and Melinda Gates. “The 2014 Gates Annual Letter: Three Myths that Block Progress for the Poor.”

that corruption can be seen as a “tax” on aid, inefficiencies brought about by unstable governments can also be seen as a tax—an inherent aspect of international aid in the developing world that, while real and disruptive, should not preclude aid altogether. Third, international aid has served as a key factor in the fight against HIV/AIDS, providing funding for programs that regularly save and improve the lives of those affected by the virus, while preventing further transmission.

Solutions to the Problem

Aid can be improved and instability can be mitigated. There are several ways to achieve these tangible and realizable goals. First and foremost, aid volatility in Kenya and other developing nations must be put to an end. The constant cycle of too much aid, followed by too little, followed again by too much, is not the fault of the recipient nations, but of the donor nations, and has real effects on the disbursement and responsible use of aid. According to Mwega, the volatility and cyclic nature of foreign aid in Kenya results in “deviations from actual plans, discontinuation of projects, and under-provision of services.”³¹⁰ Kenya’s volatility is far higher than other nations in Africa: from 1980 to 2006, volatility of foreign aid in Kenya was reported to be 24.1 percent, compared to 17.2 percent for Africa and 13.9 percent for all developing countries.³¹¹ Aid to Kenya’s health sector is even more volatile than its overall aid.³¹²

Volatility in aid continually leaves programs that depend on that aid for funding in a state of limbo, as their future is unknown. In separate studies of five organizations or programs that depended on international aid, Mwega determined that four of the organizations or programs were

³¹⁰ Mwega, 17.

³¹¹ Ibid., 35. These percentages do not refer directly to the percentage of aid that should be considered “volatile” in a particular year. Rather they are statistical interpretations of data measured by dividing the root mean squared error by the mean of the relevant aid flows during the period of study.

³¹² Ibid., 37.

directly affected by aid volatility and its implications on their own funding.³¹³ Interpreting aid as a moral imperative and ethical responsibility is an effective way of mitigating this volatility. When nations set up aid relationships with developing nations like Kenya, they enter into a fiduciary relationship with the recipient that must be respected and maintained.

As an example, consider a hypothetical CBO that is funded by PEPFAR and which provides ARTs to 5,000 HIV+ Kenyans in Kibera. Every week, the patients arrive at the clinic and collect the ARTs that they take regularly. As a result of the treatments, these Kenyans are able to live normal lives, working several jobs to ensure that their children can attend school. When funding from PEPFAR is stable and constant, the patients can obtain ARTs for years consecutively. Now imagine that the U.S. government decides that aid to Kenya is no longer necessary, and that the money could be put to better use in some other area. Funding for the clinic is cut off, the supply of ARTs dries up, and now 5,000 HIV+ Kenyans in Kibera are without medicine. Without access to medicine, their health will rapidly deteriorate, and they will no longer be able to work their several jobs. This is the reality of international aid, and this is why it cannot be cut off until the recipient nation is able to provide these services on its own.

Critics of international aid will again argue that this results in dependency on donor aid. Again, they are missing the point. There are many examples of countries that have depended heavily on international aid in the past yet now are almost completely free of dependency. With international assistance, Kenya and the rest of sub-Saharan Africa will soon be the same way.

Other critics often argue that the United States and other developed nations should “focus on problems at home” before addressing the problems that exist in other parts of the world. This selfish, ethnocentric worldview has little basis in fact. First, the less than one cent from every U.S.

³¹³ Ibid., 37.

tax dollar that goes to foreign aid gets a massive return on investment, literally saving millions of lives per year. Second, if all aid were to be ended, the relatively tiny amount of money saved would not be nearly enough to solve these so-called “problems at home.” Third, there are several areas in which the United States can save money more effectively and ethically than in foreign aid (e.g., the USD \$650 billion-plus military budget).

While aid does work and must be kept constant, there are ways in which its implementation can be improved. In his paper on international aid to Kenya, Mwega argues that better coordination between donor agencies could lead to improved efficiency for international aid.³¹⁴ When several different governments provide funding to several different organizations through several different divisions and bureaucracies, it is understandable that some of the target destinations are double-covered while others are left out. Although this communication could be improved by having a centralized agency like UNAIDS taking over joint command of funding from each donor nation, such an arrangement would be difficult to organize between the dozens of nations that provide aid to the developing world. Instead, donor nations should focus on improving transparency by reporting more details on where and how their international aid is being spent. This will not only hold donor nations more accountable for the destinations of their taxpayers’ dollars, it will also permit better coordination by the NGOs and nations receiving the funds.

Perhaps most importantly, donor aid must be made more culturally specific. A shift from the donor interest model to the recipient need model of international aid would effectively allow for this change to occur. Too often, international aid comes with specific requests from donor nations (e.g., PEPFAR’s emphasis on teaching abstinence until marriage). These directives are generally (though not always) well-intentioned—they simply take what worked in the donor nation

³¹⁴ Ibid., 37.

and hope to apply it to the recipient nation. The problem that arises, however, is that what works in one nation does not always work in another.

Education about HIV/AIDS in the United States, for example, looks very different from HIV/AIDS education in Kenya. Responses to HIV/AIDS in the United States as opposed to Kenya look just as different, in large part because the two areas have such vastly disparate perspectives on the disease. In the U.S., HIV/AIDS generally affects less than one percent of the population. In Kenya, this rate has been as high as ten percent. As such, in the United States, HIV/AIDS is seen as a dangerous sexually transmitted infection that has long-term implications that can be managed by medicine. In Kenya, HIV/AIDS is a daily reality, a disease that directly affects one in ten people, killing hundreds of thousands of people each year who may not have access to the medicine that is relatively easy to obtain in the U.S. These differences provide a large difference in the sense of urgency of the various responses. In the U.S., HIV/AIDS is just another STI covered in health class. In Kenya, education on HIV/AIDS takes a desperate, life-or-death attitude because it absolutely must.

As the world continues to invest in healthcare in the developing world, working to improve access for those who have none, these issues—volatility, poor coordination, and lack of cultural specificity—must be addressed. Although foreign aid works, it can be improved by addressing the instability that makes it less effective and less efficient. But that instability is in no way a reason to remove aid altogether. As Gates writes in his letter, “I hope we can stop discussing whether aid works, and spend more time talking about how it can work better.”³¹⁵

³¹⁵ Bill and Melinda Gates. “The 2014 Gates Annual Letter: Three Myths that Block Progress for the Poor.”

CHAPTER EIGHT

Pharmaceutical Access

Magic Johnson, five-time NBA champion and three-time NBA MVP, has been HIV+ for nearly 25 years. He contracted the virus in the late 1980s, discovered his HIV+ status in 1991, and announced that status at a press conference a few months later.³¹⁶ Today, Magic Johnson is alive and relatively healthy, regularly appearing on television as a commentator for basketball games.³¹⁷ Yet each year, millions of HIV+ people in sub-Saharan Africa are killed by what is essentially the exact same virus. It is obvious from the outset that this represents a significant

³¹⁶ Harvey Araton, “20 Years Later, Still Alive, Still Lively,” *The New York Times*, November 5, 2011.

³¹⁷ *Ibid.*

ethical issue. Why should some people have access to life-saving treatments against HIV/AIDS and not others? If these medicines exist, why are they not manufactured in large numbers and provided to the developing world? It is important to note that the ethical issue here is not that people like Magic Johnson are receiving adequate treatment for their illness, thereby extending their lives—it is that the vast majority of the world’s HIV+ population is not. This section will focus on pharmaceutical access in Kenya specifically in the form of drugs that inhibit HIV from becoming AIDS, referred to throughout as antiretroviral therapies (ARTs). The effects of ARTs on those living with HIV are rapid, obvious, and massively beneficial. As such, this section will look for strategies that can improve public access to ARTs in Kenya.

Pharmaceutical Access in Kenya

As mentioned above, PEPFAR has been one of the dominant providers of ARTs in Kenya, delivering ARTs to half a million Kenyans since its inception, including nearly 70,000 pregnant women.³¹⁸ These numbers, though encouraging, fall far below the demand. In 2011, the last year that data was made available, ART coverage was determined to be 69 percent by the World Bank. This number indicates the percentage of Kenyan adults and children with advanced HIV infection “currently receiving antiretroviral therapy according to national approved treatment protocols among the estimated number of people with advanced HIV infection.”³¹⁹ As a point of comparison, in the United States, this number is very near 100, with almost all HIV+ Americans receiving the ARTs they require. Although Kenya’s percentage is low, it is a marked increase over previous

³¹⁸ U.S. Department of State, “Partnership to Fight HIV/AIDS in Kenya.”

³¹⁹ The World Bank, “Antiretroviral Therapy Coverage in Kenya,” 2011. <http://data.worldbank.org/indicator/SH.HIV.ARTC.ZS>.

percentages. In 2006, for example, the number was only 18 percent—evidence that programs like PEPFAR have tangible effects on the lives of HIV+ Kenyans.³²⁰

UNAIDS data support the same suppositions as the World Bank. In its 2013 report on access to ARTs, UNAIDS named Kenya one of 20 nations in the world that have an “unmet need for antiretroviral therapy” and called on the international community to “mobilize technical support to accelerate the pace of treatment scale-up.”³²¹ While the problem certainly exists there, it is in no way limited to Kenya. According to UNAIDS, only 66 percent of people around the world who require ARTs receive them.³²² In places like the United States, the United Kingdom, and Germany, HIV/AIDS has shifted from being a death sentence to being a chronic yet manageable disease. In sub-Saharan Africa, this is not yet the case.

The problems with ARTs in Kenya are further exacerbated by sociological factors that make ARTs far less effective. In a 2009 study of 830 Kibera residents receiving free ARTs from clinics close to their home, researchers found that dropout rates and adherence rates in areas of intense poverty were higher and lower, respectively, than national averages.³²³ The report reads:

Of 830 patients that started ART between January 2005 and September 2007, 29 percent dropped out of the program for more than 90 days at least once after the last prescribed dose. The dropout rate was 23 per 100 person-years, and the probability of retention in the program at 6, 12, and 24 months was 0.83, 0.74, and 0.65, respectively. Twenty-seven percent of patients had an overall mean adherence below 95 percent. Being a resident of Kibera was significantly associated with 11 times higher risk of dropout.³²⁴

³²⁰ Ibid.

³²¹ UNAIDS, “Access to Antiretroviral Therapy in Africa: Status Report on Progress Towards the 2015 Targets,” 9-10. <http://www.unaids.org/en/resources/documents/2013/name,89920,en.asp>.

³²² Ibid., 4.

³²³ Christian Unge, et al., “Challenges for Scaling Up ART in a Resource-Limited Setting: A Retrospective Study in Kibera, Kenya,” *Journal of Acquired Immune Deficiency Syndromes* 50 (2009): 397-402.

³²⁴ Unge, et al., 399. The researchers defined “dropout” as a patient who had not showed up 90 days after the last prescribed dose.

Essentially, the study found that nearly a third of Kibera residents who began ART regimens dropped out, and 27 percent of those who remained with the trial often did so erratically. These high rates of dropout and low rates of adherence indicate unequivocally the connection between poverty and low standard of living and adherence to drug regimens and prescriptions. When an HIV+ Kenyan needs to be more concerned with making money to buy food for his or her family, he or she is far less likely to be able to make the time to return to a clinic regularly to obtain ARTs.

The study by Unge et al. was performed in relation to free ARTs. The situation is understandably even worse when ARTs require payment. In a separate study which compared the efficacy of free ARTs versus those that require payment, researchers found that rates of follow-up were far lower in programs that required payment.³²⁵ The study reads: “Payment for ART is associated with a significantly higher rate of loss to follow-up, as some patients might be unable to sustain payment over time.”³²⁶ When payment was required, other problems were observed beyond dropouts, as well. Some patients in the study diluted their drug regimen by taking less than the prescribed amount per day, either to extend the lifetime of their supply or to share the medicine with an HIV+ family member, thereby reducing the effectiveness of the ARTs in order to save money.³²⁷

A larger, societal problem with ARTs is that they are frequently the victim of ignorant criticism. One such argument against ARTs is that they increase the number of people living with HIV/AIDS, and, as such, contribute to the continual spread of the virus. There is some truth behind this claim. For example, if a 20-year-old HIV+ person does not receive ARTs, they might die

³²⁵ R. Zachariah, et al., “Payment for Antiretroviral Drugs is Associated with a Higher Rate of Patients Lost to Follow-up Than Those Offered Free-of-Charge Therapy in Nairobi, Kenya,” *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 102 no. 3 (2007): 288-93.

³²⁶ Ibid., 290.

³²⁷ Ibid., 293.

within ten years of contracting the virus, and during that time might only have a few sexual partners. But, if that person was to receive ARTs, their life might be extended by 40 years, vastly increasing their opportunity to have more sexual partners. Add in the fact that sexual activity might be increased by wellbeing, and this theory appears to have some credibility.

Yet there are two decisive points against such an argument. First, even though ARTs do increase the number of people in a country living with HIV/AIDS (see Figure 4, above) does that mean that HIV+ people should just be left to die? Should the international community sacrifice the lives of millions of people to kill off HIV/AIDS? Such a suggestion is preposterous, and is reminiscent of Ebenezer Scrooge's wish that the poor would die to "decrease the surplus population"—both wildly unethical and statistically inaccurate.

Second, the data show that ARTs do not result in increased risky sexual behaviors, but rather mitigate them. In a study performed in 2007, researchers found "no evidence of increased risky sexual behaviors among those receiving ART for 12 months."³²⁸ In fact, Luchters et al. found that there was "a substantial reduction" in risky behaviors when analyzing three factors: unprotected sex with partners of unknown HIV status, condom use, and number of sexual partners.³²⁹ The study showed that there was a statistically significant decrease in unsafe sex from 50 percent in the year preceding ART to 28 percent in the year following.³³⁰

These results are encouraging. They show not only that ARTs are effective in extending the lives of people living with HIV, but also that regular attendance to drug regimens results in a decrease in risky sexual behaviors. This association between education and ARTs is a direct result of "more frequent encounters with health workers" and the many other benefits (condom

³²⁸ Stanley Luchters and Avina Sarna, et al., "Safer Sexual Behaviors After 12 Months of Antiretroviral Treatment in Mombasa, Kenya: A Prospective Cohort," *AIDS Patient Care and STDs* 22 no. 7 (2008): 587-94.

³²⁹ Ibid., 589.

³³⁰ Ibid.

provision, counseling, etc.) associated with ARTs.³³¹ As a result of the data collected, the researchers argue that, “In resource-limited settings, ART should be offered free of charge in order to promote treatment compliance and prevent the emergence of drug resistance.”³³²

Unfortunately, ARTs are not always provided for free in sub-Saharan Africa, for a variety of reasons. Perhaps the most often cited reason for this lack of access is patents that protect the manufacture of drugs designed and discovered by pharmaceutical companies. On the one hand, patents provide justification and funds for future investments in medical research on behalf of both scientists and pharmaceutical companies. On the other hand, patents limit the availability and increase the cost of life-saving treatments, and are often seen as negatively affecting the availability of comprehensive healthcare in impoverished nations. In the introduction to his paper, “Trips, Pharmaceutical Patents, and the HIV/AIDS Crisis: Finding the Proper Balance Between Intellectual Property Rights and Compassion,” John Harrelson summarizes this dichotomy well:

Patent protection plays an important role in promoting economic growth by offering incentives for investment in the development of new products...recently, the issue of affordability of HIV/AIDS medications has caused debate on the proper strength of pharmaceutical patent protection. Much of the conflict between those who support strong patent rights and those who oppose them has focused on the use of compulsory licensing and parallel imports as mean to of [sic] lowering HIV/AIDS pharmaceutical prices in poorer countries. Even liberal compulsory licensing and parallel imports, however, may not sufficiently lower the cost of these pharmaceuticals to make them affordable in the poorest countries.³³³

Essentially, the problem with HIV/AIDS and pharmaceuticals comes down to the common justification: “the pills might cost five cents to make now, but the first one cost two billion dollars.” A huge amount of money must be poured into drug development over decades in order to see success—scientists need to be hired, instruments and chemicals need to be purchased, several

³³¹ Ibid., 591.

³³² Ibid.

³³³ John Harrelson, “Trips, Pharmaceutical Patents, and the HIV/AIDS Crisis: Finding the Proper Balance Between Intellectual Property Rights and Compassion,” *Widener Law Symposium Journal* 7 (2001): 175-201.

clinical trials need to be funded and supported, etc. Once all of that is complete, often the synthesis and production of drug regimens is quite easy. But without adequate compensation, pharmaceutical companies have no economic incentive to develop more drugs, or improve the ones that they have already developed. They rely on healthcare providers—and, transitively, patients—to pay for their old drugs in order to fund future development.³³⁴

The title of Harrelson's paper, however, is significant in that it asserts that there is a balance to be found that simultaneously respects the needs of pharmaceutical companies and the dignity of human beings living in impoverished areas of the world. There are many ways for the international community to approach and achieve this balance.

Solving the Problem

Prices for ARTs are already dropping in sub-Saharan Africa. For example, from 2011 to 2013, the annual price for medicine to prevent mother to child transmission of HIV dropped from USD \$800 to USD \$100.³³⁵ In South Africa, the cost of ARTs is USD \$113 per person per year—the lowest price anywhere in the world—as a result of competitive bidding.³³⁶ To continue

³³⁴ These issues have been debated at length, and will not be discussed in depth here so as to remain focused on the issue at hand. It is important to note, however, that there is an ongoing argument on the best way to encourage pharmaceutical companies to invest in future drug development while offering their current drugs to the developing world for reduced prices (or for free). On the one hand, the pharmaceutical industry defends their current practices by citing the life-saving effects that their drugs have and the huge costs they endure in the development phase of each drug. They also argue that for every successful drug that is made, dozens upon dozens of unsuccessful drugs require similar investments of time, money, and effort. On the other hand, activists and NGOs who work in the developing world provide arguments that generally center on the right of all human beings—regardless of where they live—to the healthcare that the richest nations in the world enjoy. While this at first sounds like an argument that plays only to the emotions, there is real substance and value on this side, as well. These NGOs and activists offer up real solutions to the problem, some of which are discussed in this section, like tiered pricing, the control of parallel imports, and the manufacture of generics in certain situations. For a survey of this issue, see *Patent Rights in Developing Countries*, by Jakkrit Kuanpoth, *The WTO and India's Pharmaceuticals Industry*, by Sudip Chaudhuri, and *Ethics and the Pharmaceutical Industry*, by Michael Santoro. *Beyond Philanthropy* by Ken Bluestone, sponsored by OXFAM, provides a good basis for the latter set of arguments.

³³⁵ UNAIDS, "Around 10 Million People Living with HIV Now Have Access to Antiretroviral Treatment." June 30, 2013. <http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2013/june/20130630pr-treatment/>.

³³⁶ Ibid.

improving access to ARTs for HIV+ Kenyans, however, prices must be brought down even more than they already have been.

There are many ways that this can be accomplished. First, pharmaceutical companies should make efforts to promote tiered pricing. Tiered pricing refers to the sale of identical drugs for different prices depending on where in the world they are being consumed. For example, in a developed nation like the United States with generally wide insurance coverage and a high GDP, ARTs might cost USD \$600 per month.³³⁷ In countries like Kenya, almost no NGO or CBO and certainly very few individuals would be able to afford such a price. By offering these drugs to Kenyans at a lower cost than that offered in the United States, both parties benefit. Kenyans who are HIV+ receive ARTs that can prolong and improve their lives, while the pharmaceutical companies tap into a market that they otherwise would not have been able to sell to, albeit at a much smaller profit margin.

Unfortunately, in many cases, this profit margin is far too low to justify tiered pricing for pharmaceutical companies, a fact Harrelson acknowledges: “In reality, the profit on drugs would be nonexistent or so small that a tiered pricing solution is unattractive for pharmaceutical companies despite the human suffering that the drugs could prevent.”³³⁸ An additional disincentive for tiered pricing is the threat of parallel imports—essentially, individuals or companies purchasing the pharmaceuticals at the lower prices in the developing world, transporting them to countries like the United States, and selling them at a far lower price than the pharmaceutical company intended for that country.³³⁹

³³⁷ National Institutes of Health, “Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents,” *AIDS Info*, February 12, 2013.

³³⁸ Harrelson, “Trips, Pharmaceutical Patents and the HIV/AIDS Crisis,” 201.

³³⁹ *Ibid.*

Nevertheless, tiered pricing has contributed to the decrease in cost of ARTs in Kenya, and can continue to do so in the future. One way of encouraging tiered pricing is for a developed country providing aid, like the United States, to subsidize the pharmaceutical companies for offering their drugs at lower prices to nations in need. The U.S. already does this through PEPFAR—expansion of such a program would result in the provision of ARTs for even more people who need them. International participation in a subsidy program for pharmaceutical companies would be most effective—the combined financial resources of the developed world would be more than enough to subsidize the development of new drugs and the provision of life-saving treatments to the nations in the world who most need them yet cannot afford them.

Another strategy for ensuring better access to pharmaceuticals in the developing world is the case-by-case, partial restriction of intellectual property rights in cases where they begin to trump human rights. In a paper titled “Access to Affordable HIV/AIDS Drugs: The Human Rights Obligations of Multinational Pharmaceutical Corporations,” Lissett Ferreira cites the TRIPS agreement—the Agreement on Trade Related Aspects of Intellectual Property Rights—as justifying that “under certain circumstances, it is legal and appropriate to limit intellectual property rights to achieve broader societal goals.”³⁴⁰ The author argues that the HIV/AIDS crisis is such a case, and that the international community and drug companies have an obligation to respect the rights of developing states to affordable HIV/AIDS treatment.

One way of limiting these intellectual property rights in order to achieve the social goal of an HIV-free world is to expand and increase the manufacture of generic drugs. Generics is a term that refers to identical copies of brand-name drugs, which have the same dosage, use, effects, side effects, strength, etc. Traditionally, generic drugs have been seen as a threat to pharmaceutical

³⁴⁰ Lissett Ferreira, “Access to Affordable HIV/AIDS Drugs: The Human Rights Obligations of Multinational Pharmaceutical Corporations,” *Fordham Law Review* 71 (2003): 1133-80.

companies and a violation of their intellectual property. Companies in the developing world—especially India—would obtain the composition of a particular drug, manufacture it without having to do any of the initial research, and sell it for far lower prices.³⁴¹

Many sub-Saharan African nations have laws against the use of generic drugs, ostensibly in order to improve their relationship with multinational pharmaceutical companies. For example, until 2012, the Kenyan government was operating under a ruling that severely limited access to affordable and essential drugs to treat HIV/AIDs, simply because they were generic.³⁴² This had direct effects on the wellbeing of some Kenyans, who were dependent on generic drugs due to their effectiveness and lower cost. The campaign of pharmaceutical companies against generic drugs is reasonable, in the sense that it can undermine their business practices, make drug research unsustainable, and have long-term implications on the development and implementation of future medicines. At the same time, there are ways to protect drug companies from the negative effects of the manufacture of generics.

First, patents on drugs that have significant life-saving ability should not apply to countries in which they are desperately needed. This would enable the manufacture and use of generics, which could result in better healthcare for the massive number of people struggling with preventable, treatable diseases in the developing world. In order to prevent these generic drugs from negatively impacting pharmaceutical development, parallel imports should be prevented in the case that they are obviously and maliciously circumventing the rights of the pharmaceutical companies to their own intellectual property.

As an example, consider a hypothetical ART, developed by an American pharmaceutical company, which effectively prevents HIV from becoming AIDS and extends the lifetime of HIV+

³⁴¹ S. Arun, “Kenyan Court Ruling a Boost for Indian Generics Exports,” *BusinessLine*, April 25, 2012.

³⁴² *Ibid.*

patients by 30 or 40 years, while also significantly increasing their wellbeing. Such a drug could see wide application in Kenya if its patent were lifted and generics were able to be used there. Kenya would be able to import generics of that drug from India, and thousands of lives would be improved as a result. So long as the U.S. government and the rest of the developed world enforced and protected their borders from parallel imports of these generics, the profitable market for the pharmaceutical company—namely, the rich countries—would be protected. Such an arrangement would ensure not only that those who need them obtain ARTs, but also that the cycle of drug research and development is not adversely affected.

Beyond access, distribution can also be improved. In their research, Unge et al. found a few ways to decrease the dropout rate and increase the adherence rate for HIV+ patients on ARTs. The first and most obvious strategy is to ensure that ARTs are always provided free to those who need them. As the research by Zachariah et al. showed, paid services for ARTs negatively affected patient retention and the success of the ART.³⁴³ When patients do not regularly attend for their medicine, their health can rapidly deteriorate, and the ARTs that they have taken to that point are essentially wasted.³⁴⁴ Further exacerbating the problem is the threat of drug resistance, which can develop when patients who take nucleoside reverse transcriptase inhibitors/nonnucleoside reverse transcriptase inhibitors do not adhere strictly to the drug regimen prescribed.³⁴⁵ As such, retaining patients is of crucial importance to their health and to the effectiveness of ARTs. Research shows that offering the medicine for free is the most important and effective way to achieve this.

Another strategy that should be employed to improve the effectiveness of ARTs is the use of “adherence support workers” to work with patients and ensure retention.³⁴⁶ According to Unge,

³⁴³ Zachariah, R., et al., “Payment for Antiretroviral Drugs,” 293.

³⁴⁴ Unge, Christian, et al., 399

³⁴⁵ Ibid. The vast majority of ARTs in sub-Saharan Africa fall into this category.

³⁴⁶ Ibid.

et al., these support workers are often indigenous people living with HIV/AIDS who work with their neighbors to ensure that they stick closely to their regimen. There are many reasons why these support workers provide an excellent method for ensuring patient retention.³⁴⁷ First, they are better able to connect on a personal level with the patient, as they not only speak the same language but also come from the same place and struggle with the same disease. Second, they are better able to communicate why sticking closely with the regimen is so important. Third, they can act as a friend and confidant rather than a clinical health worker, and thus are better able to understand the needs and difficulties with which each particular patient is struggling. This improves patient monitoring, allowing health workers to spot early warning signs of low adherence or dropout more easily.³⁴⁸

Though HIV has not been cured, ARTs provide a way of extending and improving the lives of HIV+ people indefinitely. In the developed world, HIV/AIDS has been turned from a horribly debilitating, lethal virus into one that can be controlled. As drugs continue to improve, the lives of HIV+ people improve equally. Today, in some parts of the world, HIV+ people live happy, healthy, and full lives. In other parts, those living with HIV struggle on a daily basis to survive, infants are infected regularly during childbirth, and the cycle repeats itself.

This ethical problem has a crystal clear solution: access to life-saving pharmaceuticals in the developing world must be improved. Bill Gates wrote, “I have believed for a long time that disparities in health are some of the worst inequities in the world—that it is unjust and unacceptable that millions of children die every year from causes that we can prevent or treat.”³⁴⁹ Improving access to ARTs can bring an end to this injustice, terminating the cycle of systematic violence that regularly violates the human dignity of millions of Kenyans.

³⁴⁷ Ibid.

³⁴⁸ Ibid.

³⁴⁹ Bill and Melinda Gates. “The 2014 Gates Annual Letter: Three Myths that Block Progress for the Poor.”

Part Three:

Moving Forward

CHAPTER NINE

Lessons for the Future

In light of the discussion above, there are clearly many takeaways from the HIV/AIDS epidemic in Kenya that can serve as lessons for the future. This section will move through each of the areas referenced above, quickly addressing key lessons that Kenya has taught us and briefly forecasting the immediate future in each area. While HIV/AIDS prevalence is on the decline in most nations in sub-Saharan Africa, the number of people living with HIV/AIDS is steadily increasing, and the fight against the virus is far from over. Using the experience that the global community has had so far with HIV/AIDS in Kenya, what are the ways in which we can address the many ethical issues that HIV/AIDS so clearly exacerbates—and is so clearly exacerbated by—in other countries struggling with the epidemic?

Education

One thing that this project makes clear is that HIV/AIDS education comes in many different forms, ranging from traditional school-based education, to programs held by CBOs, to social advertising campaigns paid for by the government and NGOs. Education is a key factor in the fight against HIV/AIDS, because it has been shown by research with a high degree of certainty to prevent and control the spread of the virus.³⁵⁰

In Kenya, education is steadily improving, in part because of better teaching and education standards put forth by the government, and in part because of the involvement of so many NGOs and foreign donors. The amount of money being put toward education in Kenya has steadily increased over the last 30 years, and it is likely to continue to do so in the near future, especially if rumors of free secondary education come to fruition. Though there have been setbacks, like the teacher's strike of 2013, it appears that education—in all of its forms—is improving throughout Kenya. But up to today, what have we learned from education in Kenya in terms of HIV/AIDS?

First, Kenya has taught us that life skills education works most effectively in addressing HIV/AIDS, because it not only provides young people with the knowledge of the biological implications of HIV/AIDS, but also empowers them to make safe decisions that protect themselves and their partners. It teaches HIV/AIDS as a serious illness that must be part of a broader discussion, thereby instilling young people with a better understanding of the overall issue and the value of prudence in making decisions about their sexuality. Second, while education specifically on HIV/AIDS is crucial for combatting the epidemic, education in general has also been shown to have positive effects on HIV prevalence, as well. Expanding access to education across the board is an important step in decreasing HIV prevalence. Third, NGOs, CBOs, and the Kenyan

³⁵⁰ Anne Bakiiiana, et al., "Accelerating the Education Sector Response to HIV/AIDS in Africa," ix; Alexandria Valerio and Don Bundy, "Education and HIV/AIDS."

government should continue to expand the role of social advertising in combatting HIV/AIDS. Edutainment like the soap opera *Siri*, endorsements by prominent Kenyan celebrities, and traditional television, print, and billboard advertisements have all contributed to the overall mainstreaming of HIV/AIDS in Kenya. And while this success may have resulted in the nation becoming a victim of its success by inundating the population with HIV/AIDS information, it is far better to be a victim of one's success than simply a victim. If social advertising on HIV/AIDS continues to fall off as it has in recent years, HIV/AIDS will be perceived as less of an issue by the population regardless of the fact that it continues to affect a large percentage of the population. Fourth, the growth and development of CBOs that provide educational programs should be encouraged by providing tax breaks, supplies, and financial assistance. CBOs provide a route of education separate from schools, and can serve as a safety net in the case that a person fails to receive a traditional education. CBOs are also crucial in adult education, which is highly important in nations where the level of education of adults is relatively low on average.

Gender Inequality

In general, women remain largely discriminated against in sub-Saharan Africa as a whole, and their opportunities are far lower than their male counterparts. In terms of HIV/AIDS, this inequality makes women much more vulnerable to the virus than males, on average, and limits their ability to receive effective prevention and treatment options. By forcing women into abusive sexual relationships, permitting males to have multiple sexual partners, and posing significant barriers to a woman's ability to access life-saving medicine, societies can significantly impede the ability of women to live the same type of healthy life that many men are granted.

In Kenya, there is some hope that this trend is coming to an end. The recent outcry after a female parliamentarian was assaulted on television shows—at the very least—that men and women who care about gender equality are able to stand up and say so. And while the response by the general public to that particular event was not entirely favorable, there are signs that more and more Kenyans are coming to realize the injustice of a society that categorically gives preference to men over women.

In addition, Kenya's new constitution provides a route for the advancement of women's rights. It not only spends several paragraphs defining and condemning crimes against women and girls, it also declares the universality of human rights and equality under the law for both men and women. If activists are able to capitalize on this message, progress will be made. Change on the issue of gender inequality in Kenya will likely not come in a sweeping and categorical fashion, but will instead take many years of persistence activism to be realized, just like it has in so many countries before Kenya.

If this progress on gender inequality will take time, however, interventions must be taken in the immediate future to mitigate the effects that inequality has on HIV/AIDS prevalence. The role of women's support groups, often operated under the auspices of CBOs established specifically for women, are crucial in the advancement of women's rights. These organizations not only provide at-risk and HIV+ women with tangible improvements to their healthcare like VTC and, in the case of those already infected, ARTs—they also provide benefits that empower them as individuals in their community. These benefits include job and skills training and business loans, which allow women to become financially stable, removing the need for them to become sex workers or to rely on the financial resources of a male, which may put them at greater risk for HIV infection.

Perhaps the greatest solution to the problem of gender inequality in Kenya in the long-term is ensuring that girls and young women receive the same educational opportunities that men do. Providing boarding programs for women is an effective way to remove them from the abusive relationships and forced labor at home that often negatively impact their education. The improvement of scholarship options for women is a further step that nations must take not only to ensure that more females graduate high school, but that they go on to successful careers as engineers, physicians, lawyers, and politicians. Slowly but surely, this movement will end the widely-held perception that women in sub-Saharan Africa are less than their male counterparts.

Sexuality

Much as discrimination against women creates problems that make them more vulnerable to HIV/AIDS infection, stigma against those who identify as GLBTQ does the same. Because public opinion in much of sub-Saharan Africa is so strongly against homosexuality, this problem is one of the most difficult to address in terms of HIV/AIDS prevention and treatment. Unfortunately, recent developments in sub-Saharan Africa do not paint an optimistic picture for the advancement of GLBTQ rights in the near future.

In February of 2014, President Yoweri Museveni of Uganda signed into law an “anti-gay” bill, despite threats from the international community.³⁵¹ The law authorizes life sentences in prison for the charge of “aggravated homosexuality,” and represents a significant step backwards for a part of the world that already discriminates strongly against the GLBTQ community.³⁵² The president and many of the nation’s citizens justified the law by claiming that homosexual behavior

³⁵¹ Alan Cowell, “Uganda’s President Signs Anti-Gay Bill,” *The New York Times*, February 24, 2014.

³⁵² Ibid.

negatively impacts the fight against HIV/AIDS, and that it is against God's plan for mankind.³⁵³ Though the law was met with significant outcry, most of it came from the developed world, or from particularly outspoken African public advocates like Desmond Tutu. As regrettable as the situation is, the reality is that stigma against homosexuality remains widely supported throughout the majority of sub-Saharan Africa, and will be supported for the foreseeable future.

With that being said, there are several tangible steps that must be taken in order to address the issue and mitigate the effects of HIV/AIDS on the GLBTQ community in the meantime. First, lawyers, politicians, physicians, and religious leaders must begin to address the issue of homosexuality on the level of basic human rights. While some may oppose homosexual behavior on religious or moral grounds, they should nevertheless see the need for those who identify as GLBTQ to receive the same medical treatment options as straight men and women. Second, education on the issue of sexuality should be expanded through both schools and CBOs. Sexuality and homosexuality should be addressed explicitly in any life skills education courses like AHAPPY, because it is so clearly an ethical issue which holds back significant progress against HIV/AIDS.

The difficulty with homosexuality on a societal level in sub-Saharan Africa is that it is seen by many to be a disorder or a choice—by providing education on the issue, these backward notions can be reversed. Perhaps most important in this effort are religious leaders, who to this point have generally encouraged stigma and discrimination against homosexuals. Of all people, religious leaders should be most aware of the need to respect and promote the dignity of all human beings, regardless of their sexual orientation.

³⁵³ Ibid.

Poverty

Beyond these inequalities, there is the inherent inequality of poverty, which very clearly inhibits the ability of those who struggle with it to receive education, adequate healthcare, and to flourish as human beings. Poverty is not simply the way the world works—it is an ethical issue that shortens the lives of those most affected by it. Luckily, there is much optimism in the fight against poverty. Bill Gates, whose foundation works in all corners of the world to mitigate the effects of poverty and bring healthcare to those who need it most, recently made a bold prediction—he claims that by 2035, “there will be almost no poor countries left in the world.”³⁵⁴ Specifically, he argues that by our current definitions, almost all countries will be lower-income or richer by 2035. Nevertheless, wealth inequality will still exist in all of the world’s countries, but it will mostly exist in nations that are self-sufficient and no longer rely on international assistance to provide for their citizens.

In order to validate this bold prediction, the developed world must continue to supply the international assistance that already helps to mitigate the effects of poverty on a daily basis. This international aid has improved many countries—like Brazil, Costa Rica, and Morocco—so significantly that they are no longer dependent on international aid to combat poverty. In addition, the provision of free medical services—like VTC and ARTs—is imperative in countries where the poverty rate is particularly high. It is clear from a variety of studies that poverty prevents those struggling with it from regularly accessing the medicine and counseling that helps control HIV and prolong the lives of those living with the virus. By providing medical services free of charge, and in some cases, even incentivizing the services further, NGOs and CBOs can ensure better attendance by those living in poverty.

³⁵⁴ Bill and Melinda Gates. “The 2014 Gates Annual Letter: Three Myths that Block Progress for the Poor.”

International Aid and Instability

International aid, as exemplified by PEPFAR, has helped the global community make significant strides against HIV/AIDS, and can continue to do so in the future. First, a global shift from the donor interest model to the recipient need model for foreign aid will allow for more effective use and disbursement of funds, while allowing for cultural specificity that has been lacking to date. While it is reasonable for a donor nation to have its own interests in mind when providing international aid, these interests should not come at the expense of the most effective use of aid.

That is not to say, however, that international aid should just be thrown at poorer nations to do with what they please. Although corruption is likely a smaller problem than most assume, it nevertheless is a problem. To mitigate these problems without micromanaging the use of funds, the United States and other donor nations should be more transparent with their international aid so that its use—and abuse—can be scrutinized more closely by donor nations, recipient nations, and independent organizations. This will result in better feedback and quality control, which will in turn improve the disbursement and use of international aid.

Pharmaceutical Access

Just as international aid can be improved, the provision of pharmaceuticals to the developing world can be improved as well. It is simply and obviously unethical that millions of people die from preventable diseases each year, and the situation needs to be rectified as efficiently as possible. First, encouraging pharmaceutical companies to tier prices is an effective strategy to allow for sales to flourish, particularly in nations that are neither rich nor extremely poor. In the poorest nations, these pharmaceuticals must be provided for less than they cost. The only way to

accomplish this without removing all incentives from drug research and development is either to allow for the manufacture and use of generics, or to have donor nations subsidize pharmaceutical companies that provide their drugs free of charge in the developing world—or both.

While statistics on HIV/AIDS are depressing, the above few paragraphs should provide both hope and motivation. Hope, because there are tangible steps that can be taken to help mitigate the global effect of HIV/AIDS, and motivation, because many of these steps have not yet been started.

CHAPTER TEN

Conclusion

Progress towards a cure for HIV continues to be encouraging.³⁵⁵ Although it is difficult to predict, it is possible that widespread treatments that cure HIV could be available for use in the next 50 years, pending significant breakthroughs by researchers. And while these treatments might take some time to reach the world's poorest nations, it is also possible that the world could nearly be free of HIV/AIDS by the start of the 22nd century.

Consider, for example, a few of the diseases that have caused widespread death within the last 100 years: polio, smallpox, and influenza. For most of the world, these are illnesses that now

³⁵⁵ Kristina Allers, et al., "Evidence for the Cure of HIV Infection by CCR5Δ32/Δ32 Stem Cell Transplantation," *Blood* 117 no. 10 (2011): 2791-9; Donald G. McNeill, "Early Treatment is Found to Clear H.I.V. in a Second Baby," *The New York Times*, March 5, 2014.

fall into one of two categories—either they are nearly eradicated, or they are completely immunizable.

Polio, for example, has been reduced from 350,000 cases, endemic in 125 countries in 1988, to fewer than 250 cases, endemic in just three countries in 2008.³⁵⁶ This 99 percent reduction in polio cases over just a 20-year period has come at a significant cost—more than USD \$1 billion per year worldwide—but the results are clear: the world is rapidly approaching polio-free status. Smallpox is one of the deadliest diseases in human history, accounting for 300 to 500 million deaths in the 20th century alone.³⁵⁷ Yet since 1979, the world has been free of smallpox, after successful—and expensive—vaccination campaigns starting in the mid-20th century. Influenza, on the other hand, was responsible for the deaths of between 20 and 40 million people in 1918 alone.³⁵⁸ The world still struggles with the flu, but yearly vaccinations limit the virus' area of effect and deadliness. While these statistics do not change the number of people dying from HIV/AIDS each day, they serve to show that incredibly deadly diseases have been conquered by the combined efforts and resources of the global community. Perhaps in 100 years HIV/AIDS will be the same.

Knowing this, why does a project like this one matter? If the disease will eventually be gone, are the lessons learned here valuable indefinitely? The answer to this question, quite simply, is yes.

Although HIV/AIDS is an exceptional disease and has often been referred to as such throughout its history, it does not exist in a vacuum. Its effects, as shown above, are wide-ranging and horribly damaging at nearly all levels of society. At the same time, however, the many ethical

³⁵⁶ Gates Foundation, “What We Do: Polio,” accessed March 31, 2014, <http://www.gatesfoundation.org/What-We-Do/Global-Development/Polio>.

³⁵⁷ David Koplow, *Smallpox: The Fight to Eradicate a Global Scourge* (Berkeley: University of California Press, 2004), 115.

³⁵⁸ Jeffrey Taubenberger, “1918 Influenza: The Mother of All Pandemics,” *Influenza* 12 no. 1 (2006).

issues discussed above would likely still exist whether or not HIV ever migrated to human beings and created the global epidemic with which we struggle today. If steps are not taken to address these ethical issues, they will likely survive HIV/AIDS the same way they preceded it. And while the thought of a world free of HIV/AIDS is encouraging, it is less encouraging to imagine that world still home to oppressive poverty, discrimination against women and people who identify as GLBTQ, political violence and instability, and massive disparities in healthcare and education between nations.

As progress on HIV/AIDS continues and the world hopefully controls—and maybe cures—the scourge with which it has battled for more than 30 years, it is possible that the entire global community could become victims of its success in the same way that Kenya has in its campaign to mainstream HIV/AIDS. Curing HIV/AIDS will not rid the world of the ethical issues discussed here, though it will certainly help. We must not see the end of HIV/AIDS as the antidote for the problems facing Kenya and the rest of the developing world, and instead must see it as one of many steps toward ensuring that all members of the world's future generations—regardless of where the ovarian lottery places them—have an equal opportunity to flourish as human beings and live the healthy, happy, and full lives that each of us deserves.

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